

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 10533 CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <u>MD</u> b. COUNTY <u>1</u> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | | | c. LENGTH OF STAY IN lb <u>5 months</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stella Maris Hospice</u> | | | | | | d. STREET ADDRESS <u>1304 Medfield Ave.,</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>Kenny</u> Last <u>Adair</u> | | | | | | 4. DATE OF DEATH Month <u>8</u> Day <u>4</u> Year <u>1967</u> | | | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3/15/1894</u> | | 9. AGE (In years last birthday) <u>73</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswf</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Columbus, Ohio</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Michael Joseph Kenny</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Dukin</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>226-07-2262</u> | | 17. INFORMANT <u>Hospice records</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Ca</u> 1992 DUE TO <u>Primary Site Not Determined</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u> | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u> </u> e.m. p.m. <u> </u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) <u> </u> | | (County) <u> </u> | | (State) <u> </u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2/28/67</u> to <u>8/4/67</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>8/1/67</u> , 19 <u> </u> , and that death occurred <u>8:15 AM</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Robert Mahon</u> | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>8/4/67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Robert Mahon, M.D.</u> | | | | | | 22d. ADDRESS <u>204 E. Joppa Rd. Towson</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>8/7/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>BALTO NATIONAL</u> | | | | 23d. LOCATION (City, town or county) (State) <u>BALTO. MD.</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Paul E. Chavira</u> | | | | | | 25a. REC'D BY REGISTRAR DATE <u>AUG 8 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

MEDICAL CERTIFICATION

232

— *Journal of the American Medical Association*

2/5/72 2B 11-20 B

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10534

10534

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore-Towson</u> c. LENGTH OF STAY IN 1b <u>18 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Treater Baltimore Medical Center</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Stonabury Hill Road</u> d. STREET ADDRESS <u>Stonabury Hill Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward Andrew Adelsberger</u> | | | | 4. DATE OF DEATH Month Day Year <u>August 19 1967</u> | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Aug 9, 1888</u> | | 9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HAIRDRESSER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE</u> | | 11. BIRTH PLACE (County & State, or foreign country) <u>BALTIMORE</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John Adelsberger</u> | | | | 14. MOTHER'S MARDEN NAME <u>Anna NASH</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <u>No</u> (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>213-30-1288</u> | | 17. INFORMANT <u>Pts. chart</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Massive pulmonary edema</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 19____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8-19</u> , 19 <u>67</u> , to <u>8-14</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8-19</u> , 19 <u>67</u> , and that death occurred at <u>7:08 PM</u> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>Jose M. de Leon</u> M.D. | | | | | | | | 22b. DATE SIGNED <u>8-19-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>JOSE M. DE LEON, M.D.</u> | | | | 22d. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>8/22/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Wm. WATTERS MEM. CEM. COOPSTOWN, MD.</u> | | 23d. LOCATION (City, town or county) (State) <u>COOPSTOWN, MD.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Wm. COOK-BROOKS TOWSON 1050 YORK RD. 21204</u> | | | | 25a. REC'D BY REGISTRAR <u>AUG 24 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |



17 3 7

x

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10535

10535

| | | | | | | | |
|--|----------------------------------|---|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westowne | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 334 Westshire Road | | | | d. STREET ADDRESS 334 Westshire Road | | | |
| 3. NAME OF DECEASED (Type or print) Wayne E. Aldrich | | | | 4. DATE OF DEATH Month August Day 24 , Year 1967 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-27-1898 | 9. AGE (In years lost birthday) 69 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heating Contractor | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Glen Falls, N.Y. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Herbert Aldrich | | | | 14. MOTHER'S MAIDEN NAME Minnie Cashion | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. 218-18-4368A | | 17. INFORMANT Address Mrs. Gertrude I. Aldrich, 334 Westshire Rd. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Generalized CARCINOMATOSIS DUE TO (b) Adenocarcinoma of Lung DUE TO (c) 6 mos + | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Peptic ULCER STOMACH | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from MARCH , 19 67 , to 8/24 , 19 67 , that (I) (we) last saw the deceased alive on 8/24 , 19 67 , and that death occurred at 6 P M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Dr. T. E. Roach | | | | 22b. DATE SIGNED 8/25/67 | | 22c. PHYSICIAN'S NAME (Type) Dr. T. E. Roach | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 8-28-1967 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | |
| 24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue | | | | 23d. LOCATION (City or Town) (County) (State) Baltimore County, Maryland | | 25a. REC'D BY REGISTRAR 21229 | |
| 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | 25c. DATE AUG 28 1967 | | | |

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

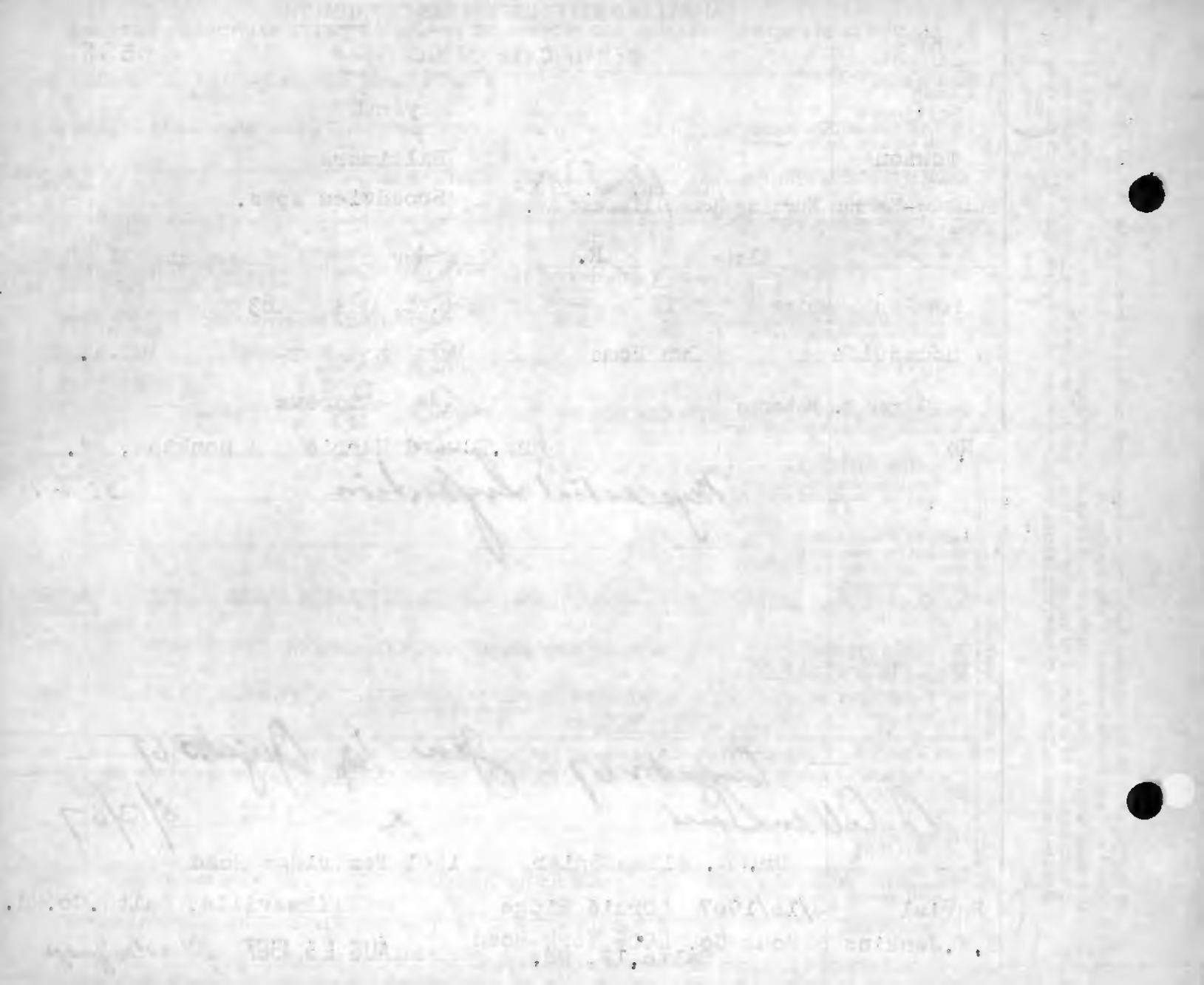
RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|----------------------------------|--|---|--|---|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 10536 | | | | | CERTIFICATE OF DEATH | | | | | 10536 | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b Towson, Md. 21204 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dulaney-Towson Nursing Home, 111 West Rd. | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS Broadview Apts. | | | | | 6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Elsie Middle R. Last Alexander | | | | | 4. DATE OF DEATH Month August Day 13 Year 1967 | | | | | | | | | | | | | | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 2, 1884 | | 9. AGE (In years last birthday) 83 yrs. | | IF UNDER 1 YEAR Months 30 Days 4 | | IF UNDER 24 HRS. Hours 1 Min. 0 | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | | | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | |
| 13. FATHER'S NAME Oliver P. Roberts | | | | | 14. MOTHER'S MAIDEN NAME Ida E. Andrews | | | | | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | | 16. SOCIAL SECURITY NO. 4301 | | | | | 17. INFORMANT Mrs. Edward Harris | | | | | Address Monkton, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4301 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 30 hrs | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 1967 to August 1967 , that (I) (we) last saw the deceased alive on August 1967 and that death occurred at 3:42 PM from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE Dr. A. Allan Spier | | | | | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22b. DATE SIGNED 8/13/67 | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) Dr. A. Allan Spier | | | | | | | | | | 22d. ADDRESS 1501 Pentridge Road | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | 23b. DATE THEREOF 8/16/1967 | | | | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge | | | | | 23d. LOCATION (City, town or county) (State) Pikesville, Balto. Co. Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | | | | | | | | | ADDRESS 1905 York Road Balto. 12, Md. | | | | | 25a. REC'D BY REGISTRAR AUG 15 1967 | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>---</u> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore.</u> <u>30-4</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u> | | | | | | d. STREET ADDRESS <u>6030 Alta Ave.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | First <u>John</u> Middle <u>Taylor</u> Last <u>Allan, Jr.</u> | | 4. DATE OF DEATH Month <u>8</u> Day <u>19</u> Year <u>1967</u> | | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Can</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>10-20-07</u> | | 9. AGE (In years last birthday) <u>59</u> yrs. | | IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>National Claim Ser.</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Canada</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>John Taylor Allan, sr.</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>McCallum, Margaret.</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WW II</u> | | | | 16. SOCIAL SECURITY NO. <u>377-10-9872</u> | | 17. INFORMANT Address <u>Eileen R. Allan, 6030 Alta Ave.</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary - Respiratory failure</u> <u>1992</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ca of abdominal cavity with involving</u> (c) <u>all organ</u> DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>---</u> a.m. <u>---</u> p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7-11</u> , 19 <u>67</u> , to <u>8-19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/19</u> , 19 <u>67</u> , and that death occurred at <u>8:25</u> M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Kenny Nardi</u> | | | | | | ATTENDING PHYS. <input type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <u>8/19/67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. Navidi</u> | | | | | | 22d. ADDRESS <u>GBMC</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>8/23/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore, National Cem.</u> | | 23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Leonard J. Ruck, inc. 5305 Harford Rd.</u> | | | | | | 25a. REC'D BY REGISTRAR DATE <u>AUG 22 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

of abnormal crop with many
birds - especially flocks

Handwritten notes and signatures at the bottom of the page, including a signature that appears to read "Handwritten" and some illegible text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|--|--|---------------------------------------|--|---|--|--|--|--|------------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 10538 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY BALTO MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY BALTO | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ARBUTUS | | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ARBUTUS | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1714 SELMA AVE. | | | | | | d. STREET ADDRESS 1714 SELMA AVE. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First HARRY Middle DORSEY Last ARMSTRONG | | | | | | 4. DATE OF DEATH Month AUG. Day 15 Year 1967 | | | | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Nov 6, 1875 | | 9. AGE (In years last birthday) 91 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk | | | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVMT. | | 11. BIRTHPLACE (County & State, or foreign country) MD. | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME Richard D. Armstrong | | | | | | 14. MOTHER'S MAIDEN NAME Helena Walker | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT Lore Armstrong - 1714 Selma Ave. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) infirmities of age PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 1 yr 10 mos | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from ? , 1967, to 8-16 , 1967, that (I) was last saw the deceased alive on 8/16 , 1967, and that death occurred at 2 P.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE B B Brumbaugh | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED 8/17/67 | | |
| 22c. PHYSICIAN'S NAME (Type) B B Brumbaugh | | | | | | 22d. ADDRESS 3609 Main St Elkridge MD 21927 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8-18-1967 | | 23c. NAME OF CEMETERY OR CREMATORY Linden Park | | | | 23d. LOCATION (City, town or county) (State) Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR Forbes Cronan L J & Co Baltimore, Md. | | | | | | 25a. REC'D BY REGISTRAR AUG 22 1967 | | 25b. REGISTRAR'S SIGNATURE Charles J. J... | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10539

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10539

| | | | | | | | | | | |
|--|----------------------------------|---|---|--|---|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7122 Heathfield Road | | | | d. STREET ADDRESS 7122 Heathfield Road | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | First LEMA Middle PEARL Last BAILEY | | 4. DATE OF DEATH | | Month August Day 9 Year 19 67 | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 19, 1922 | | 9. AGE (In years past birthday) yrs 45 | 10. IF UNDER 1 YEAR Months Days Hours Min | | 11. IF UNDER 24 HRS Hours Min | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Alabama | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME S.F. Bailey | | | | 14. MOTHER'S MAIDEN NAME Bama Gardner | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | | 16. SOCIAL SECURITY NO 418-22-0863 | | 17. INFORMANT Mr. Warren Bailey Address Los Angeles, Calif. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Contact gunshot wound of chest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot self | | | | | | | |
| 20c. TIME OF INJURY Month Day, Year Hour a.m. 8-9- 19 67 p.m. | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home | | 20f. (City or town) (County) (State) Baltimore Md. | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Charles S. Springate</i> EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | | 22. DATE SIGNED August 10, 1967 | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CA. EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) | | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial-Transit | | 23b. DATE THEREOF 8-12-67 | | 23c. NAME OF CEMETERY OR CREMATORY Pine Crest | | | 23d. LOCATION (City or Town) (County) (State) Mobile, Alabama | | | |
| 24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. Baltimore, Maryland 21212 | | | | ADDRESS 6500 York Rd. | | 25a. REC'D BY REGISTRAR AUG 15 1967 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | |



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10540

10540

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) rural, Baltimore c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3817 Patterson Ave | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY *Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Baltimore d. STREET ADDRESS 3817 Patterson Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Charles Egerton Bald First Middle Last 4. DATE OF DEATH Aug 28 1967 Month Day Year | | 5. SEX Male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH June 19, 1896 Yrs. Months Days Min. | |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marketing clerk 9b. KIND OF BUSINESS OR INDUSTRY Standard Oil Co 10. BIRTHPLACE (County & State or foreign country) Balto. Md. 11. CITIZEN OF WHAT COUNTRY? U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Bald | | 14. MOTHER'S MAIDEN NAME Isabelle Barnitz | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW 1 | | 16. SOCIAL SECURITY NO. 212-09-0287 17. INFORMANT Mrs. Ida M. Bald Address Balto. 7 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4011 DUE TO myocardial infarction Anteroselective heart disease Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from ... 1967 to Aug 29, 1967, that (I) (we) last saw the deceased alive on July 19, 1967, and that death occurred at 2 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Paul H Royse 22c. PHYSICIAN'S NAME (Type) Paul H Royse | | 22b. DATE SIGNED Aug 29, 1967 22d. ADDRESS 1403 Foley La. Pikesville Md 21208 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 8/31/67 23c. NAME OF CEMETERY OR CREMATORY Lorraine 8728 Liberty Rd Randallstown Md. | | 23d. LOCATION (City, town or county) (State) Woodlawn, Balto Co. Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Spring Byers | | 25a. RECD BY REGISTRAR AUG 30 1967 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10541

10541

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN lb 54 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS 3409 E. LOMBARD STREET | |
| 3. NAME OF DECEASED (Type or print) First ELLIS Middle J. Last BEACH | | 4. DATE OF DEATH Month AUGUST Day 30 Year 19 67 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 23, 1897 |
| 9. AGE (In years last birthday) 70 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) CORK GRINDER | |
| 11. BIRTHPLACE (County & State, or foreign country) FAIRFAX COUNTY, VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME THOMAS BEACH | | 14. MOTHER'S MAIDEN NAME MARY FORBES | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes give war or dates of service) WW I YES | | 16. SOCIAL SECURITY NO 212 01 52 39 | |
| 17. INFORMANT CLIN. RECORDS VA HOSPITAL, FT HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYELOGENOUS LEUKEMIA, CHRONIC DUE TO 2041 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from 7/7/67 , 19__, to 8/30/67 , 19__, that (I) (we) last saw the deceased alive on 8/30/67 , 19__, and that death occurred at 7:25 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>[Signature]</i> | | 22b. DATE SIGNED 8/30/67 | |
| 22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M. D. | | 22d. ADDRESS VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 9-2-67. | |
| 23c. NAME OF CEMETERY OR CREMATOR Sacred Heart Cemetery | | 23d. ADDRESS 401 German Hill Rd. Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR <i>[Signature]</i> Charles S. Zeiler | | 25a. REC'D BY REGISTRAR DATE SEP 5 1967 | |
| 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

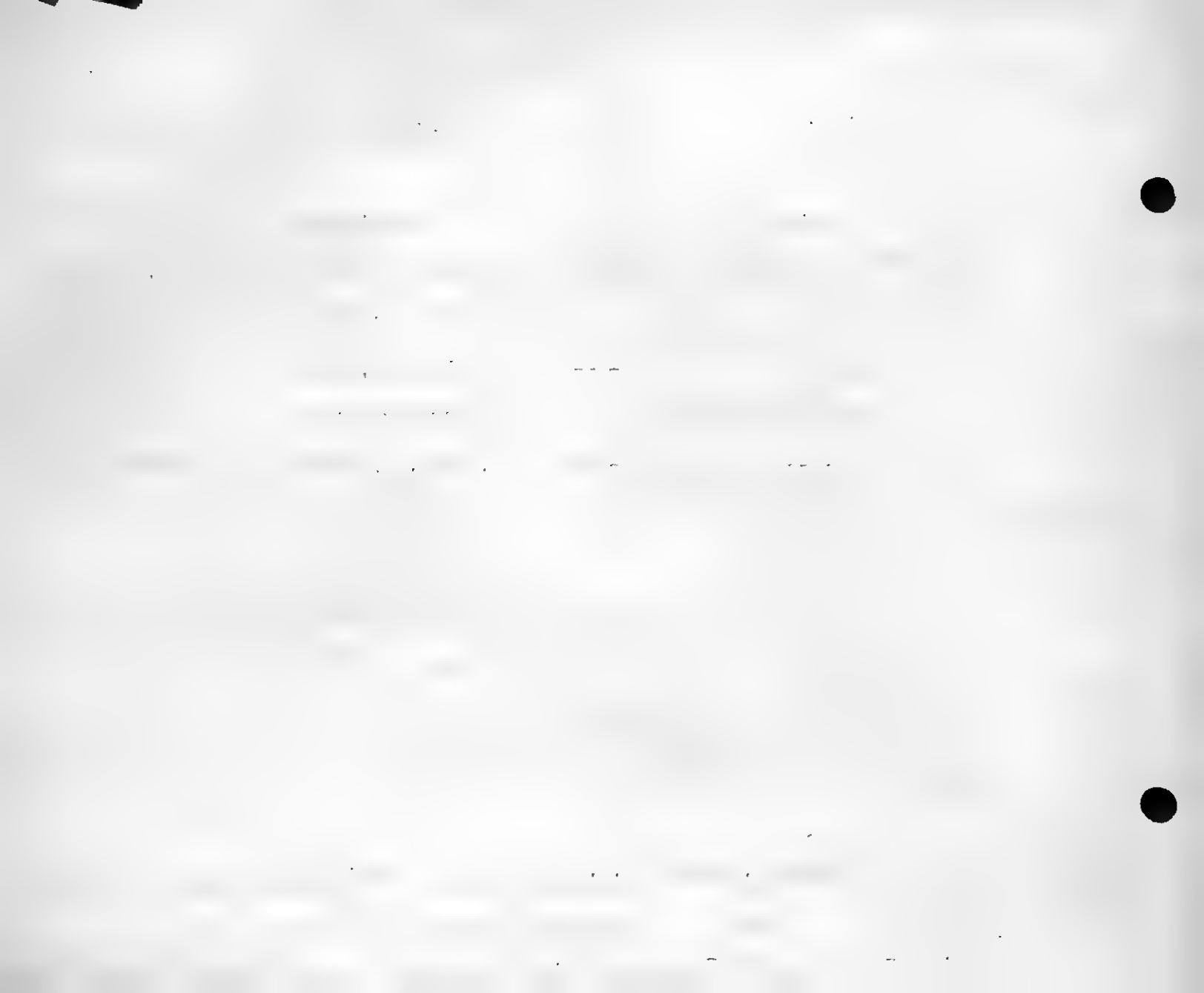
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/68

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN lb life | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. tol, give street address) 423 Hopkins Road | | d. STREET ADDRESS 423 Hopkins Road | |
| 3. NAME OF DECEASED HELEN (Type or print) First (NELLIE) Middle JOHNSTON Last BECKWITH | | 4. DATE OF DEATH August 2nd, 1967 19 Month Day Year | |
| 5. SEX Female | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 16, 1877 |
| 9. AGE (in years last birthday) 89 yrs | | 10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Patrick Johnston | | 14. MOTHER'S MAIDEN NAME Mary McElroy | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 214-03-0282 B | |
| 17. INFORMANT Mr. Chas. L. Beckwith-116 Register Avenue | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) antiseptic C.U. Dis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 9, 1964 to July 9, 1967 , that (I) (we) last saw the deceased alive on July 31, 1967 , and that death occurred at _____ M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Edward L. Glassman | | 22b. DATE SIGNED 8/2/67 | |
| 22c. PHYSICIAN'S NAME (Type) EDWARD L. GLASSMAN M.D. | | 22d. ADDRESS 4037 Falls Rd. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/4/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery | | 23d. LOCATION (City or Town) (County) (State) Balto. | |
| 24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home-6500 York Rd. 21212 | | 25. REC'D BY REGISTRAR AUG 4 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

10543

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10543

| | | | |
|---|-------------------------------------|--|---|
| 1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PRIMECOST NURS. HOME</u> | | d. STREET ADDRESS <u>5314 Good Now Rd.</u> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last <u>MAIDA Louise Bender</u> | | 4 DATE OF DEATH Month Day Year <u>8 9 19 67</u> | |
| 5 SEX <u>F</u> | 6 COLOR OR RACE <u>W</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>6-2-93</u> |
| 9 AGE (In years last birthday) <u>74</u> yrs | | 10 IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12 CITIZEN OF WHAT COUNTRY? | |
| 13 FATHER'S NAME <u>HERMAN MIEKE</u> | | 14 MOTHER'S MAIDEN NAME <u>HILDA A/BRECHT</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16 SOCIAL SECURITY NO | |
| 17 INFORMANT <u>MRS. C. EASTWOOD</u> | | Address <u>6101 Acker</u> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion Sudden</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a) <u>10 yrs</u> noting the underlying cause lost. DUE TO <u>Cardio Renal Vascular Disease</u> (c) <u>Fractured Right Hip</u> <u>4 wks</u> | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> | | 22. DATE SIGNED <u>8/9/67</u> | |
| EXAMINER'S NAME (Type) <u>Charles F. O'Donnell, M.D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF <u>8-12-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE</u> | 23d. LOCATION (City or town) (County) (State) <u>BALTO. CO. MD</u> |
| 24 FUNERAL DIRECTOR <u>JOHN C. MILLER INC</u> | | 25a. REC'D BY REG. STRAR <u>6415 Belair Rd.</u> | |
| 25b. REG. STRAR'S SIGNATURE <u>Charles Judge</u> | | DATE <u>AUG 14 1967</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---------------------------|--|--|--|---|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u> | | | | c. LENGTH OF STAY IN 1b <u>52 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Foxlegh Nursing Home</u> | | | | | | d. STREET ADDRESS <u>3911 7 Mile Lane</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Bernstein</u> Last <u>Bernstein</u> | | | | | | 4. DATE OF DEATH Month <u>Aug.</u> Day <u>11</u> Year <u>1967</u> | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11-9-1889</u> | | 9. AGE (In years last birthday) <u>77</u> yrs. | | 10. FUNERAL YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | | | 11. BIRTHPLACE (County & State, or foreign country) <u>Springfield, Massachusetts</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Joseph Bernstein</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Jennie Friedagot</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>212-26-3247A</u> | | 17. INFORMANT <u>Mr. Jonas I. Lipman, 3503 Old Court Road #8</u> | | | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>DUE TO</u> (c) <u>DUE TO</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GIANT Follicle Lymphoma</u> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (<u>who has been</u>) attended the deceased from <u>June 4, 1967</u> , to <u>Aug 11, 1967</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>August 8, 1967</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Howard H. Gendason</u> | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>August 11, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>HOWARD H. GENDASON MD.</u> | | | | | | 22d. ADDRESS <u>REISTERSTOWN, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>8/13/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u> | | 23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u> | | | | | | 25a. REC'D BY REGISTRAR <u>AUG 15 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10545

CERTIFICATE OF DEATH

10545

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 21218 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21218 d. STREET ADDRESS 1525 Kingsway Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Albert William BEST, Sr. | | 4. DATE OF DEATH Month Day Year August 12, 19 67 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 25, 1898 |
| 9. AGE (In years lost birthday) 69 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Mm. | 11. IF UNDER 24 HRS Months Days Hours Mm. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY B. & O. Railroad | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Samuel C. Best | | 14. MOTHER'S MAIDEN NAME Mary I. Tarleton | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 705-05-7982 | |
| 17. INFORMANT Mrs. Mary K. Best | | Address (Same) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Pulmonary infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary-thrombo embolism (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) acute pancreatitis | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> or work or work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that Dr. (this hospital) attended the deceased from July 20, 19 67 , to August 12, 19 67 , that we (we) last saw the deceased alive on August 12, 19 67 , and that death occurred at 9:15 M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE | | 22b. DATE SIGNED 8-12-67 | |
| 22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela Gomez M.D. | | 22d. ADDRESS 7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/16/1967 | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. |
| 24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | 25a. REC'D BY REGISTRAR AUG 15 1967 | |
| ADDRESS 4905 York Rd. Balto. 12, Md. | | 25b. REGISTRAR'S SIGNATURE | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VR A15ME (5)
6M 1/67

10546

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10546

| | | | | | |
|--|---------------------------------|---|---|---|--|
| 1 PLACE OF DEATH a COUNTY Baltimore Co. MARYLAND | | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY 21212 Baltimore | | |
| b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Towson | | c LENGTH OF STAY IN 1b | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | | d STREET ADDRESS 6004 Clearspring Road | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3 NAME OF DECEASED (Type or print) Robert Henry Bieneman | | | 4 DATE OF DEATH Month August Day 13 Year 1967 | | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH March 29, 1951 | | 9 AGE (In years lost birthday) 16 y/s |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b KIND OF BUSINESS OR INDUSTRY -- | | 11 BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 13 FATHER'S NAME Robert C. Bieneman | | | 12 CITIZEN OF WHAT COUNTRY? USA | | |
| 14 MOTHER'S MAIDEN NAME Joan Velenovsky | | | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No | | |
| 16 SOCIAL SECURITY NO 218-52-4966 | | | 17 INFORMANT Robert C. Bieneman (Father) Address Same | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drowning DUE TO 12:51 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) 12:51 DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH 9 Days |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Found Submerged in Pool of Water | | | |
| 20c TIME OF INJURY Month, Day, Year 12:51 pm August 4, 1967 | | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Swimming Pool | |
| 20f (City or town) | | 20g (County) | | 20h (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Charles F. O'Donnell | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED 8/13/67 | |
| EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE THEREOF Aug. 17, 1967 | | 23c NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Balto. Md. | |
| 23d LOCATION (City or town) | | 23e (County) | | 23f (State) | |
| 24 FUNERAL DIRECTOR Seitz Funeral Home 5209 York Road | | 25a REC'D BY REGISTRAR AUG 15 1967 | | 25b REGISTRAR'S SIGNATURE Charles Judge | |
| ADDRESS Eugenia K. Seitz Balto. Md. 21212 | | | | | |

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10547

| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville c. LENGTH OF STAY IN lb 10547 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kingsville | | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY 10547 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville d. STREET ADDRESS Box 270, Route 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) JOHN J. BLISSEL First Middle Last 4 DATE OF DEATH August 14, 1967 Month Day Year | | 5 SEX Male 6 COLOR OR RACE White 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH 11-11-1902 9 AGE (In years last birthday) 64 yrs F UNDER 1 YEAR Months Days Hrs Min 10a. OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer 10b. KIND OF BUSINESS OR INDUSTRY Army Chemical Center 11 BIRTHPLACE (State or foreign country) New Kensington Penna. 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME John J. Blissel | | 14 MOTHER'S MAIDEN NAME Catherine Splean | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16 SOCIAL SECURITY NO 15068 | |
| 17 INFORMANT Walker Funeral Home New Kensington Pa. | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) | |
| ACTUAL SIGNATURE Werner U. Spitz, M.D. | | 22. DATE SIGNED 8/15/67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8-17-1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | | 23d. LOCATION (City or town) (County) (State) West Moreland Co. Penna. | |
| 24 FUNERAL DIRECTOR Lasach Funeral Home 7401 Belair Rd | | 25a. REC'D BY REGISTRAR DATE AUG 16 1967 | |
| ADDRESS (36) | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10548 Item #8 Film #9327 7/15/67 DR

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> CATONSVILLE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>13A</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore Co.</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Balto. Co.</u> | |
| c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u> | | d. STREET ADDRESS <u>1107 McAdoo Rd</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Caton Ridge Nursing Home</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Beatrice</u> Middle <u>Maria</u> Last <u>Beck</u> | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>12</u> Year <u>1967</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/2/70</u> |
| 9. AGE (In years last birthday) <u>96</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>10</u> Days <u>12</u> Hours <u>12</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Penns. / PA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Zwickler, FRED</u> | | 14. MOTHER'S MAIDEN NAME <u>CLARA HAYES</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>220-52-2154</u> | |
| 17. INFIRMANT <u>1107 McADOO AVE</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Thrombosis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>40 yrs</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8/9</u> , 19 <u>67</u> , to <u>8/12</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8/12</u> , 19 <u>67</u> , and that death occurred at <u>12:45</u> P.M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>DR. DAVID E. ZICKAFOOSE</u> | | 22b. DATE SIGNED <u>8/12/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>DR. DAVID E. ZICKAFOOSE</u> | | 22d. ADDRESS <u>4 VF W Lane, Ellicott City, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town or county) (State) |
| <u>REMOVAL-BURIAL AUG. 15, 1967</u> | | <u>GREEN HILL</u> | <u>WAYNESBORO, PENNA</u> |
| 24. FUNERAL DIRECTOR <u>Easton Funeral Home Catonsville, Md.</u> | | 25a. REC'D BY REGISTRAR <u>AUG 15 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and return them to the funeral director. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10549

CERTIFICATE OF DEATH

10549

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne | | c. LENGTH OF STAY IN 1b Lansdowne | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 246 Second Avenue | | d. STREET ADDRESS 246 Second Avenue | |
| 3. NAME OF DECEASED (Type or print) Agnes H. Bopst | | 4. DATE OF DEATH Month August , Day 30 , Year 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-10-1905 |
| 9. AGE (In years last birthday) 62 yrs. | | 10. IF UNDER 1 YEAR Months 0 , Days 0 , Hours 0 , Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Secretary | | 10b. KIND OF BUSINESS OR INDUSTRY Frank B. Ober | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Hobson | | 14. MOTHER'S MAIDEN NAME Maude Gutermuth | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-03-6552 | |
| 17. INFORMANT Mr. Guy E. Bopst, 246 Second Avenue | | Address 21227 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. 4201 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) arterio-sclerotic heart disease DUE TO (c) many years | | INTERVAL BETWEEN ONSET AND DEATH not record | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 8-4- 19 67 to 8-30- 19 67 , that (I) (we) last saw the deceased alive on 8-30- 19 67 , and that death occurred at 10:15 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Florian P. Nadolski | | 22b. DATE SIGNED 9-1-67 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Florian P. Nadolski | | 22d. ADDRESS 2619 Hammonds Ferry Road, Balto., Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 9-2-1967 | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery | 23d. LOCATION (City or Town) (County) (State) Howard County, Maryland |
| 24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | 25a. REC'D BY REGISTRAR DATE SEP 5 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | |



CERTIFICATE OF DEATH

10550

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN lb 57 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if instit. at Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 5606 WESLEY AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MAYFIELD Middle -- Last BOYD | | 4. DATE OF DEATH Month AUGUST Day 8 Year 19 67 | |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 8/1/17 9. AGE (n years last birthday) 50 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY FARM | |
| 11. BIRTHPLACE (County & State, or foreign country) YORK COUNTY, SOUTH CAROLINA U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CLOVIN BOYD | | 14. MOTHER'S MAIDEN NAME HATTIE JAMISON | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II | | 16. SOCIAL SECURITY NO. 248 42 27 46 | |
| 17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) ARTERIOSCLEROTIC HEART DISEASE (c) PEPTIC ULCER, GASTRIC | | INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) POST OPERATIVE STATE CERVICAL LAMINECTOMY, RECENT | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (b) (this hospital) attended the deceased from 6/12/67 , 19 67 to 8/8/67 , 19 67 , that (b) (we) last saw the deceased alive on 8/8/67 , 19 67 , and that death occurred at 1:00 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Ivan L. Butler | | 22b. DATE SIGNED 8/8/67 | |
| 22c. PHYSICIAN'S NAME (Type) IVAN L. BUTLER, M. D. | | 22d. ADDRESS VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF Aug. 14, 1967 | 23c. NAME OF CEMETERY OR CREMATORY Balto. General Cem. Balto. Md. | 23d. LOCATION (City or town) (County) (State) |
| 24. FUNERAL DIRECTOR Charles H. Farrell | | 25a. REC'D BY REGISTRAR WILLIAMS FUNERAL HOME DATE AUG 14 1967 | |
| | | 25b. REGISTER'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10551

CERTIFICATE OF DEATH

10551

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY --- | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN lb 5 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | e. STREET ADDRESS 803 E. 22nd Street | |
| 3. NAME OF DECEASED (Type or print) PRESLEY | | 4. DATE OF DEATH Month 8 Day 1 Year 19 67 | |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/10/98 |
| 9. AGE (In years last birthday) yrs 69 | | 10. IF UNDER 1 YEAR Months 1 Days 1 Hours 19 Min 67 | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER STEEL COMPANY | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME PETERSON BOYD | | 14. MOTHER'S MAIDEN NAME VIRGINIA (last name unknown) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I | | 16. SOCIAL SECURITY NO. 213 07 31 89 | |
| 17. INFORMANT CLINICAL RECORDS, VAH. FORT HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ABDOMINAL CARCINOMATOSIS UNKNOWN PRIMARY SITE DUE TO UNDETERMINED Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PERITONITIS | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> ot work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from JULY 27 , 19 67 , to AUGUST 1 , 1967, that (I) (we) last saw the deceased alive on AUGUST 1 , 19 67 , and that death occurred 10:30 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>John D. Talbert</i> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D. | | 22d. ADDRESS VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF Aug 4/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY | | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR ELLIOTT FUNERAL HOME CAROLINE AND BIDDLE STS | | 25a. REC'D BY REGISTRAR DATE AUG 2 1967 | |
| 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | |
|--|------|------------------|---|---|---|--|------------------|---|--------|---|-------|------|---|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>25 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>8864 BELAIR road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Lina</u> Middle <u>Laura</u> Last <u>Bruff</u> | | | 4. DATE OF DEATH Month <u>8</u> Day <u>23</u> Year <u>1967</u> | | 5. SEX <u>F</u> | | | 6. COLOR OR RACE <u>CAUC</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | | |
| 8. DATE OF BIRTH <u>5-29-11</u> | | | 9. AGE (In years last birthday) <u>56</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table> | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | Months | Days | Hours | Min. | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico County MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | | | | | |
| Months | Days | Hours | Min. | | | | | | | | | | | | | | | | | | |
| 13. FATHER'S NAME <u>Brown</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Florence Layfield</u> | | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>216-09-8841</u> | | | 17. INFORMANT <u>Pt's chart</u> | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory failure</u> (b) <u>Secondary to extensive CA of esophagus</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) _____ 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State) _____ | | | | | | | | | | | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>30 of July, 1967</u> , to <u>23 August, 1967</u> , that (I) (we) last saw the deceased alive on <u>August 23, 1967</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Ebrahim Abtahian</u> | | | | | | | | 22b. DATE SIGNED <u>August 23, 1967</u> | | 22c. PHYSICIAN'S NAME (Type) <u>Ebrahim Abtahian</u> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>8-26-1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u> | | 23d. LOCATION (City, town or county) <u>Baltimore</u> (State) <u>Co. Md.</u> | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Lorraine Farnell</u> | | | | | | 25a. REC'D BY REGISTRAR <u>36</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | | | | | | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

10553

10553

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE CATONSVILLE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE | | c. LENGTH OF STAY IN 1b 1 year 4 mos BALTIMORE | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUMMIT NURSING HOME | | d. STREET ADDRESS 1423 REGISTER AVE | |
| 3. NAME OF DECEASED (Type or print) HILDA A. BUSHOUT | | 4. DATE OF DEATH Month Day Year AUGUST 20 1967 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/5/94 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (County & State, or foreign country) Jersey City N. J. |
| 13. FATHER'S NAME REINHOLD STEGE MAN | | 14. MOTHER'S MAIDEN NAME Louise DISQUE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No | | 16. SOCIAL SECURITY NO. 083-20-6557 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CHRONIC BRAIN SYNDROME DUE TO (b) CORONARY INSUFFICIENCY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) ASCVD. | | 17. INFORMANT CHART | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from July 3, 1967 to Aug 20, 1967 that (II) (we) last saw the deceased alive on 8/18, 1967 and that death occurred 8:45 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE E. KASATIIS | | 22b. DATE SIGNED 8/20/67 | |
| 22c. PHYSICIAN'S NAME (Type) E. KASATIIS, M.D. | | 22d. ADDRESS 1801 FREDERICK RD, BALTIMORE, MD 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8-23-1967 | 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park | 23d. LOCATION (City, town or county) (State) Balto. County, Md. |
| 24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. | | 25a. REC'D BY REGISTRAR AUG 21 1967 | |
| ADDRESS 4905 York Road Balto., Md. 21212 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10554

10554

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ivy Hall Nursing Home | | d. STREET ADDRESS 6506 Cleveland Ave. | |
| 3. NAME OF DECEASED (Type or print) First ANNA Middle D. Last BUHNER | | 4. DATE OF DEATH Month August Day 24 Year 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 28, 1871 |
| 9. AGE (In years last birthday) 95 yrs | | 10. IF UNDER 1 Year Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Alfred Selig | | 14. MOTHER'S MAIDEN NAME Mary Fladung | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT Mrs. Theresa A. Gunkel | | Address 6506 Cleveland Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 DUE TO (b) acute heart failure DUE TO (c) Arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH 1 day 10 yr. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 3 , 19 38 , to 8/24/ , 19 67 , that (I) (we) lost saw the deceased alive on 8/1/81 , 19 67 , and that death occurred at 2 A.M. , from causes on and the date stated above. | | | |
| 22a. SIGNATURE David H. Andrew | | 22b. DATE SIGNED 8/25/67 | |
| 22c. PHYSICIAN'S NAME (Type) David H. Andrew | | 22d. ADDRESS 6905 Dunmanway. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Aug. 26, 1967 | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | 23d. LOCATION (City or Town) (County) (State) Colgate, Md. |
| 24. FUNERAL DIRECTOR Ulrich Funeral Home Dundalk, Md. | | 25a. REC'D BY REGISTRAR AUG 29 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

10555

CERTIFICATE OF DEATH

10555

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|---|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased, ved, if institution Residence before admission) a. STATE Montgomery b. CITY OR TOWN (If outside corporate limits, write RURA. and give nearest town) Takoma Park - DC | |
| b. CITY OR TOWN (If outside corporate limits, write RURA. and give nearest town) Mt. Wilson | | c. LENGTH OF STAY IN TB 10 months | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital | | d. STREET ADDRESS 7339 8th Str. N.W. | |
| 3. NAME OF DECEASED (Type or print) ROBERT ASHTON CARTER | | 4. DATE OF DEATH Month 8 Day 28 Year 1967 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4.9.1902 |
| 9. AGE (in years) 65 yrs | | IF UNDER 1 YEAR Months 28 Days 19 Hours 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Auto | |
| 11. BIRTHPLACE (County & State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JOHN CARTER | | 14. MOTHER'S MARDEN NAME ELLA GRANT | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO No | |
| 17. INFORMANT Records, Mt. Wilson State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Lungs DUE TO Pulmonary Tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Tuberculosis DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 10.26.66 , 19 1967 , to 8.28 , 19 1967 , that (I) (we) last saw the deceased alive on 8.28 , 19 1967 , and that death occurred at 4:05M , from causes and on the date stated above | | | |
| 22a. SIGNATURE W. Newcomer | | 22b. DATE SIGNED 8.28.1967 | |
| 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Supt. | | 22d. ADDRESS Mt. Wilson, Maryland | |
| 23a. BURIAL, CREMATION, REMOVA (Specify) Burial | 23b. DATE THEREOF 8/30/67 | 23c. NAME OF CEMETERY OR CREMATORY Gate Of Heaven Cemetery | 23d. LOCATION (City or Town) (County) (State) Montgomery Co Md. |
| 24. FUNERAL DIRECTOR W. J. Hunterman & Son | | 25a. REC'D BY REGISTRAR 5732 Gauley WASH. D.C. | |
| 25b. REGISTRAR'S SIGNATURE James J. Judge | | 25c. DATE AUG 31 1967 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)
25M 1/67

1-24X116

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10550

10556

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN TB Baltimore 21234 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234 d. STREET ADDRESS 8712 Roper Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Steven James CARTER | | 4. DATE OF DEATH Month August Day 12 Year 19 67 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 9, 1967 |
| 9. AGE (In years last birthday) 1 yrs | | 10. IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Maryland | | Maryland | |
| 13. FATHER'S NAME James Ballard Carter | | 14. MOTHER'S MAIDEN NAME Jean Diane Gorleski | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sudden cardiorespiratory failure DUE TO Unknown cause Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that the (this hospital) attended the deceased from 8/9/ , 19 67 , to 8/12/ , 19 67 , that we (we) last saw the deceased alive on 8/12/ , 19 67 , and that death occurred at 4:45 M. , from causes and on the date stated above. | | 22a. SIGNATURE Reynaldo Orjuela-Gomez M.D. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| 22b. DATE SIGNED August 12, 1967 | | 22c. ADDRESS 7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/14/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial | | 23d. LOCATION (City or Town) (County) (State) Baltimore Maryland | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. 21214 | | 25a. REC'D BY REGISTRAR AUG 15 1967 | |
| 25b. REGISTRAR'S SIGNATURE William Judge | | | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u> c. LENGTH OF STAY IN 1b <u>1 yr.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bacon Rd.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall</u> d. STREET ADDRESS <u>Bacon Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Iven Ella Case</u> | | | | 4. DATE OF DEATH Month Day Year <u>12 17 1967</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Aug 18 1895</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Librarian</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>High School</u> | | 9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 13. FATHER'S NAME <u>Howard Jackson Case</u> | | | | 14. MOTHER'S MARRIED NAME <u>Margaret Stevenson</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>213385584</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart change from life caused secondary</u> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) <u>To Adeno Carcinoma of Tongue</u> DUE TO (c) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH <u>15 Mins</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>G. M. Francis</u> | | | | 22. DATE SIGNED <u>8/11/67</u> | | | |
| EXAMINER'S NAME (Type) <u>A-M. FRANCIS</u> | | | | Address (Street, city, town, or county) <u>PARKING, MD</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF <u>8/4/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Angelica Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Angelica, N.Y.</u> | |
| 24. FUNERAL DIRECTOR'S ADDRESS <u>Isabel Dorfman, New Freedom, Pa</u> | | | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

10558

CERTIFICATE OF DEATH

10558

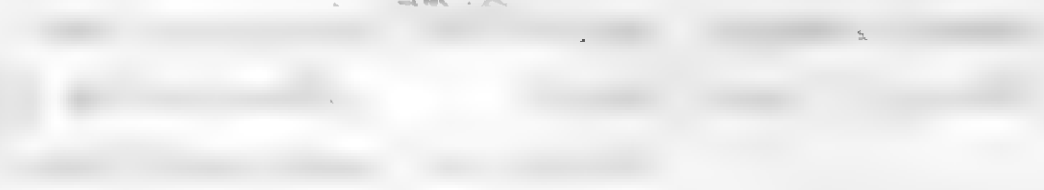
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN Tb <u>2 MONTHS</u> | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL</u> | | d. STREET ADDRESS <u>1204 OVERBROOK Rd.</u> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last <u>RUSSELL WALTER CHALK</u> | | 4. DATE OF DEATH Month Day Year <u>8 31 1967</u> | |
| 5 SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-14-15</u> |
| 9 AGE (In years last birthday) <u>52</u> yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GENERAL BAKER</u> | |
| 11 BIRTHPLACE (County & State or foreign country) <u>BALTIMORE MD.</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>EMORY EIMER CHALK</u> | | 14. MOTHER'S MAIDEN NAME <u>MARGARET KNISLEY</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO <u>220-05-7099</u> | |
| 17. INFORMANT <u>Admission Sheet</u> | | Address | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular Failure</u> DUE TO <u>163X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CP of lungs</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6-30-67</u> , 19 <u>67</u> , to <u>8-31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-31</u> , 19 <u>67</u> , and that death occurred at <u>3 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Rahim Bassiri</u> | | 22b. DATE SIGNED <u>8-31</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Rahim Bassiri</u> | | 22d. ADDRESS <u>GREATER BALTO MEDICAL CENTER</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Sept 4/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u> | 23d. LOCATION (City or Town) (County) (State) <u>Old Frederick Rd, Md</u> |
| 24. FUNERAL DIRECTOR <u>Austin E. Donovan - 3818 Poland Ave</u> | | 25a. REC'D BY REGISTRAR DATE <u>SEP 5 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u> | |

2. 1000 900 800 700 600 500 400 300 200 100 0

1000 900 800 700 600 500 400 300 200 100 0



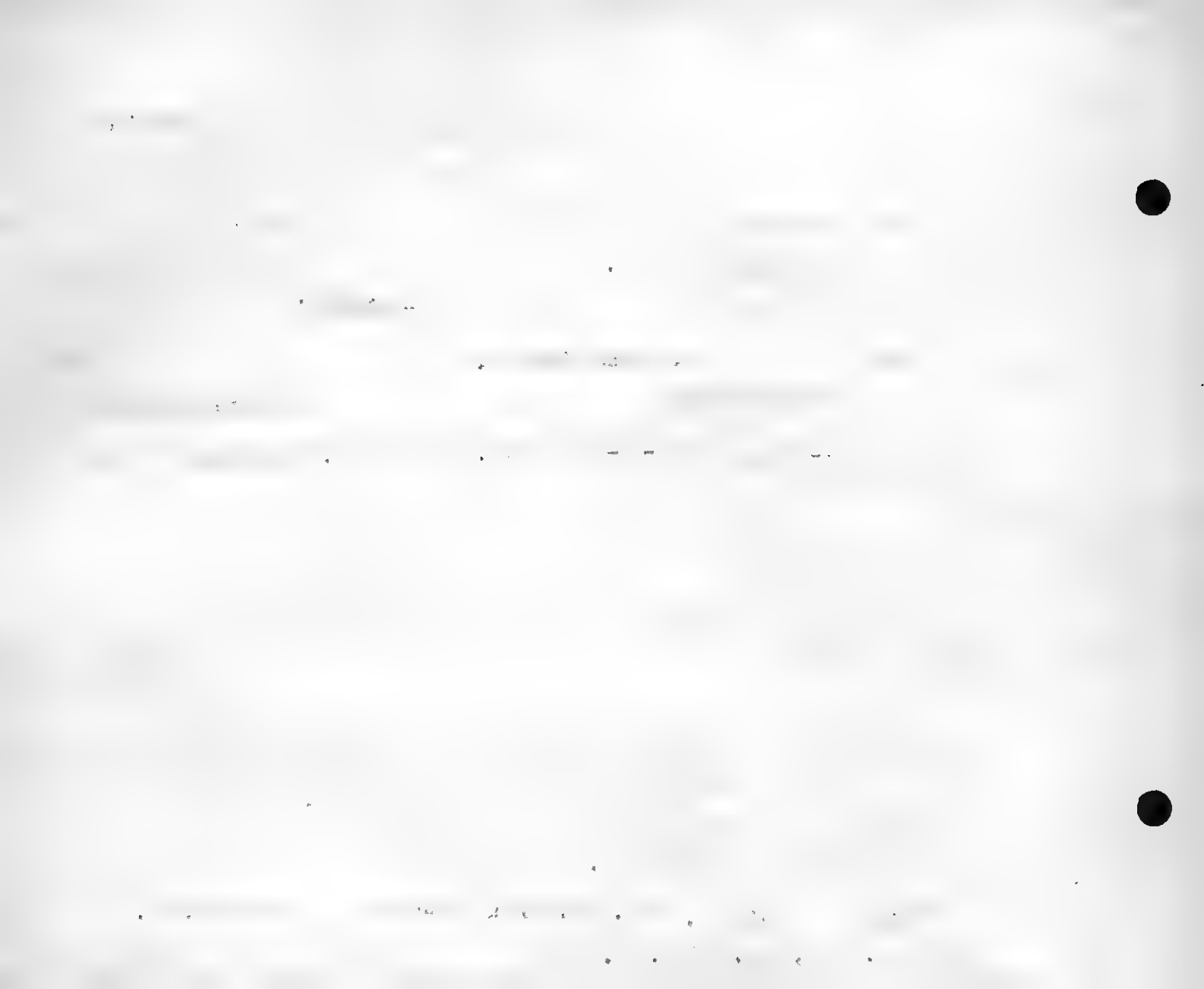
10559

CERTIFICATE OF DEATH

| | | | |
|---|---|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 21234 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 9221 Harford View Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) John J. CHLUDZINSKI | | 4 DATE OF DEATH Month August Day 22 Year 1967 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 29 Aug 1921 9 AGE (In years last birthday) 45 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Stainless Steel Co. | 11. BIRTHPLACE (County & State, or foreign country) Maryland |
| 13. FATHER'S NAME John Chludzinski | | 14. MOTHER'S MAIDEN NAME Maryanna Borkowski | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW2--Korean | | 16 SOCIAL SECURITY NO 125-01-4072 | 17 INFORMANT Address Mrs. Josephine F. Chludzinski (Same) |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) | 20f (City or town) (County) (State) |
| 21. I certify that I (this hospital) attended the deceased from July 17, 1967 , to August 22, 1967 , that I (we) lost saw the deceased alive on August 22, 1967 , and that death occurred at 2:35 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Beatriz P. Dizon</i> 22c. PHYSICIAN'S NAME (Type) Beatriz P. Dizon, M.D. | | 22b. DATE SIGNED August 22, 1967 22d. ADDRESS 7620 York Rd., Towson, Md. 21204 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/26/67. | 23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | 25a. REC'D BY REGISTRAR DATE AUG 23 1967 | 25b. REGISTRAR'S SIGNATURE <i>Charles J. [Signature]</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--------------------------------------|--|---|--|---|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH RA 13263701 T47 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u> | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | c. LENGTH OF STAY IN ID <u>12 days</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Gruber Balto. Medical Center</u> | | | | | d. STREET ADDRESS <u>3247 Chestnut Ave</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>DONALD JOSEPH CITRO</u> | | | | | 4. DATE OF DEATH Month Day Year <u>Aug 19 1967</u> | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>4-2-28</u> | | 9. AGE (in years last birthday) <u>39</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ROUTE MAN SALESMAN</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>BAKERY</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>UNKNOWN EUGENE</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>NETTIE ROSSO-ALFINITO</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>7</u> | | | | 16. SOCIAL SECURITY NO. <u>216-20-9037</u> | | 17. INFORMANT <u>PATIENT'S CHART</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Coxsackie Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4-14</u> , 19 <u>67</u> , to <u>8-19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-19</u> , 19 <u>67</u> , and that death occurred at <u>3:25 PM</u> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <u>8-19-67</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>JOSE M. DE LEON, M.D.</u> | | | | | 22d. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 23b. DATE THEREOF <u>Aug 22 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Catholicon</u> | | 23d. LOCATION (City, town or county) (State) <u>Baltimore Md</u> | | | |
| 24. FUNERAL DIRECTOR <u>Joseph St. Louis</u> ADDRESS <u>8144 36 St. B. B. Md</u> | | | | | 25a. REC'D BY REGISTRAR DATE <u>AUG 22 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send page 3 to the funeral director. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10561

CERTIFICATE OF DEATH

10561

| | | | |
|---|--|---|--|
| 1 PLACE OF DEATH a. COUNTY BALTO. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY | |
| c. LENGTH OF STAY IN 1b 25 days | | c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) BALTO. #21224 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTO. Medical Cntr. | | d. STREET ADDRESS 3314 Fleet Street | |
| 3 NAME OF DECEASED (Type or print) Joshua Green Coker | | 4. DATE OF DEATH Month 8 Day 30 Year 1967 | |
| 5 SEX MALE | 6. COLOR OR RACE CAU | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-8-05 |
| 9. AGE (In years last birthday) 62 yrs | | IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millwright | | 10b. KIND OF BUSINESS OR INDUSTRY STEEL | |
| 11. BIRTHPLACE (County & State or foreign country) BALTO. Md. | | 12. (IT ZEN OF WHAT COUNTRY?) U.S.A. | |
| 13. FATHER'S NAME Joshua Green Coker | | 14. MOTHER'S MAIDEN NAME MARY V. GREEN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 000-00-0000 | |
| 17. INFORMANT HOSPITAL CHART | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA of BRONCHUS DUE TO 16d1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with METASTASIS to BONE. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 months | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that 2 (this hospital) attended the deceased from 8/5 , 19 67 , to 8/30 , 19 67 that (1) (we) lost saw the deceased alive on 30 day Aug 19 67 , and that death occurred at 7:30 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE Duncan McElie M.D. | | 22b. DATE SIGNED 8/30/67 | |
| 22c. PHYSICIAN'S NAME (Type) DUNCAN McELIE M.D. | | 22d. ADDRESS Greater Baltimore Medical Centre | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 9-2-67. | 23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM. | 23d. LOCATION (City or Town) (County) (State) 7401 GERMAN HILL RD, BA. CO., MD. |
| 24. FUNERAL DIRECTOR Charles S. Zeiler | | 25a. REC'D BY REGISTRAR SEP 5 1967 | |
| ADDRESS 901 S. CONKLING ST. BALTO., 21224, MD. | | 25b. REGISTRAR'S SIGNATURE Charles J. Jones | |

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10562

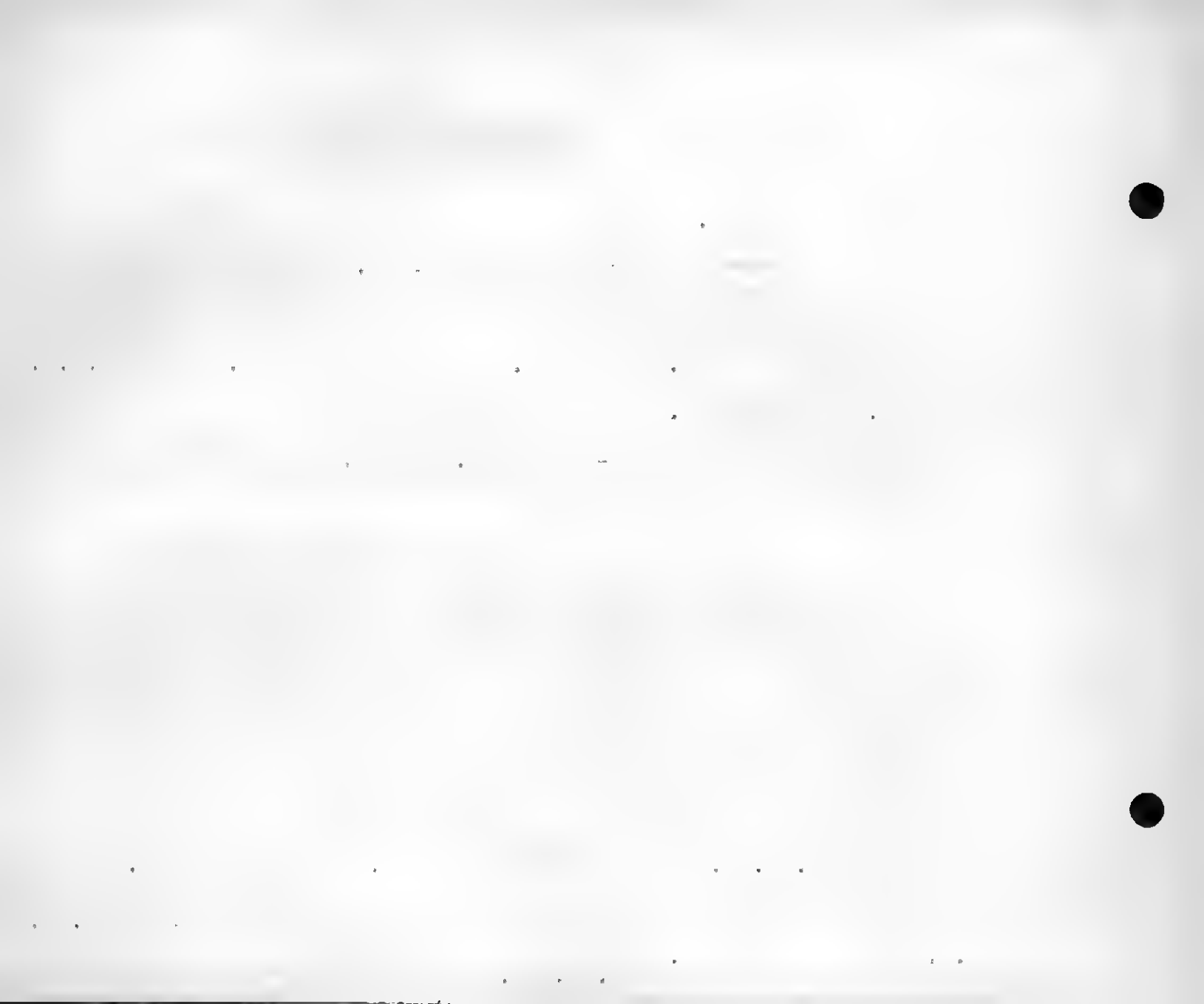
10562

CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium | | c. LENGTH OF STAY IN TB | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Five Farms (Balto. Country Club) | | d. STREET ADDRESS 221 Ridgemed Road | |
| 3 NAME OF DECEASED (Type or print) John Henry Collison, Jr. | | 4. DATE OF DEATH Month August Day 3 Year 1967 | |
| 5 SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/16/1897 |
| 9 AGE (In years lost birthday) 69 yrs. | | 10. IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Agent Comm. Mutual-Ins. | | 12. BIRTHPLACE (County & State or foreign country) Baltimore, Md. | |
| 13. FATHER'S NAME John H. Collison, Sr. | | 14. MOTHER'S MAIDEN NAME Amanda Houck | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI | | 16. SOCIAL SECURITY NO. 217-22-7811 | |
| 17. INFORMANT Mrs. Doll T. Collison | | Address (Same) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 yrs (c) | | | INTERVAL BETWEEN ONSET AND DEATH 3 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 1961 to July 27, 1967 , that (I) (we) last saw the deceased alive on July 27, 1967 , and that death occurred at 1:57 P.M. from causes on the date stated above. | | | |
| 22a. SIGNATURE Dr. K. A. Peter van Berkum | | 22b. DATE SIGNED 8/4/1967 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. K. A. Peter van Berkum | | 22d. ADDRESS 100 W. University Pkwy. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/7/1967 | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge | 23d. LOCATION (City or Town) (County) (State) Pikesville, Balto. Co. Md. |
| 24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | 25a. ADDRESS 4905 York Road Balto. 12, Md. | |
| 25b. DATE AUG 7 1967 | | 25c. SIGNATURE J. H. Jenkins | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|---|---|--|--|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 10563 CERTIFICATE OF DEATH 10563 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | | c. LENGTH OF STAY IN IB 19 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie, Maryland | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | | | | d. STREET ADDRESS 8800 Maple Street | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Wade Middle H. Last Colson | | | | | 4. DATE OF DEATH Month August Day 7 Year 19 67 | | | | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Jan. 28, 1880 | | 9. AGE (In years last birthday) yrs 87 IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) railroad | | | | 10b. KIND OF BUSINESS OR INDUSTRY Foreman | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? U. S. | | |
| 13. FATHER'S NAME Richard Colson | | | | | 14. MOTHER'S MAIDEN NAME Martha Woods | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, DUE TO old diaphragmatic Myocardial Infarction (b) Arteriosclerotic cardiovascular Ht. Dis. DUE TO Arteriosclerosis, Generalized, Senile (c) Arteriosclerosis, Generalized, Senile | | | | | | | | | INTERVAL BETWEEN DEATH AND BIRTH 24 yrs. 20 yrs. 20 yrs. | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia, Left Lower Lobe, treated, improved, org. undet. | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 19, 1967 to Aug. 7, 1967 , that <input checked="" type="checkbox"/> (we) lost the deceased alive on Aug. 7, 1967 , and that death occurred at 8:12:50 a.m. from causes on and on the date stated above | | | | | | | | | | | |
| 22a. SIGNATURE <i>Anthony J. Young</i> | | | | 22b. DATE SIGNED 8-7-67 | | | | 22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D. | | | |
| 22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF Aug 10, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. | | | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | | | ADDRESS Hyattsville, Md. | | | | 25a. RECD BY REGISTRAR DATE AUG 9 1967 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

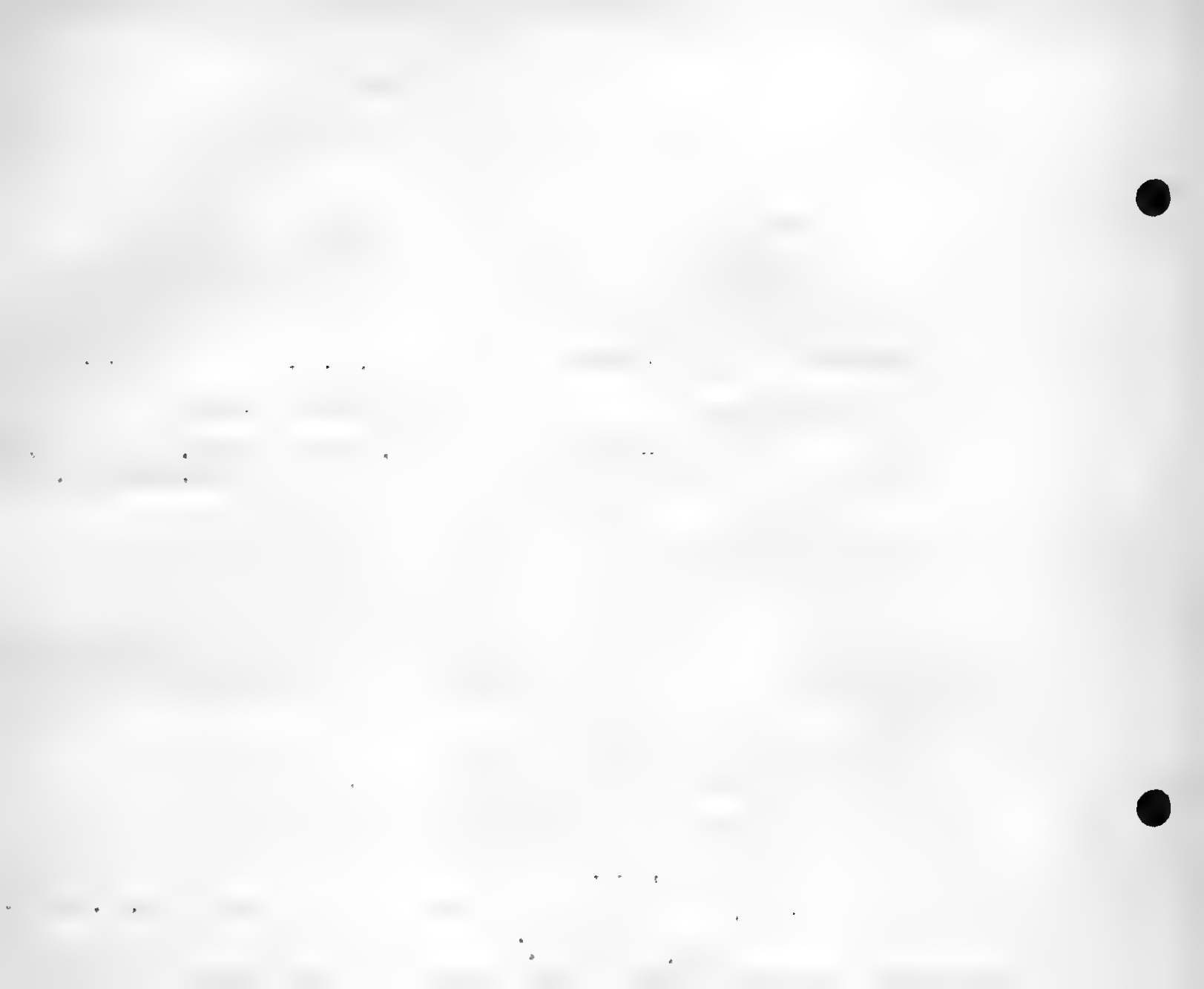
10564

10564

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY _____ | |
| c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | d. STREET ADDRESS 3324 Foster Avenue #21224 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Margaret Magdalene Cooper | | 4. DATE OF DEATH Month Day Year August 21 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 16, 1900 |
| 9. AGE (In years last birthday) 67 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | |
| 11. BIRTHPLACE (County & State, or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Hosza | | 14. MOTHER'S M A DEN NAME Katherine Steiner | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-34-7962 | |
| 17. INFORMANT Margaret E. Wilson : 706 S. Conkling St. Balto., 21224, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Diabetes Mellitus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 15, 1967 , to August 21, 1967 , that (I) (we) last saw the deceased alive on August 21, 1967 , and that death occurred at 4:50 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE V. Phupakdi | | 22b. DATE SIGNED August 21, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Vichian Phupakdi, M.D. | | 22d. ADDRESS 7620 York Road, Towson | |
| 23a. BURIAL, CREMATION, REMOVAL (Type) Burial | | 23b. DATE THEREOF 8-24-67. | |
| 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 23d. LOCATION (City or Town) (County) (State) 7225 Eastern Blvd. Ba. Co., Md. | |
| 24. FUNERAL DIRECTOR Charles S. Jiles | | 25a. REC'D BY REGISTRAR AUG 25 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Jiles | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10565

10565

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY _____ | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c LENGTH OF STAY IN TB 31yr2mth16dys | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | d STREET ADDRESS 205 North High Street | |
| 3 NAME OF DECEASED (Type or print) John | | 4. DATE OF DEATH Month August Day 30 Year 19 67 | |
| 5 SEX male | 6 COLOR OR RACE white | 7 MARRIED <input checked="" type="checkbox"/> sep. WIDOWED NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH July 4, 1899 |
| 9 AGE (in years last birthday) yrs. 68 | | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | |
| 11 BIRTHPLACE (County & State, or foreign country) Italy | | 12 CITIZEN OF WHAT COUNTRY? Italy | |
| 13. FATHER'S NAME Anthony Coppolina | | 14. MOTHER'S MAIDEN NAME Fortunata Peppitone | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. 220-56-7815 | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address _____ | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work _____ at work _____ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that he (this hospital) attended the deceased from June 14, 1936 to Aug. 30, 1967 , that he (we) last saw the deceased alive on Aug. 30, 1967 , and that death occurred at 11:30 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Stella Wachslar | | 22b. DATE SIGNED 8-30-67 | |
| 22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D. | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Sept 1 1967 | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | 23d. LOCATION (City or Town) _____ (County) _____ (State) _____ Old Federal Rd Baltimore |
| 24. FUNERAL DIRECTOR Private Funeral Home 1216 S. Chasest 30 | | 25a. REC'D BY REGISTRAR DATE SEP 5 1967 | 25b. REGISTRAR'S SIGNATURE James Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10566

CERTIFICATE OF DEATH

10566

| | | | |
|--|-----------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>White Hall</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | c. LENGTH OF STAY IN 1b <u>1 hour</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Med Ctr.</u> | | e. STREET ADDRESS <u>Rt. #1 Box 7</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Anita Elizabeth Cornthwaite</u> | | 4. DATE OF DEATH Month <u>8</u> Day <u>11</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Can</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-18-96</u> |
| 9. AGE (In years last birthday) <u>70</u> yrs | | 10. IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>19</u> Min. <u>47</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Dept Store</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Hartford Co. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Calvin Whiteford</u> | | 14. MOTHER'S MAIDEN NAME <u>Ellen Whiteford</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO <u>220-18-9450</u> | |
| 17. INFORMANT <u>Patients chart</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pulmonary edema</u> DUE TO <u>Congestive Heart Failure</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8-11-1967</u> to <u>8-11-1967</u> that (I) (we) last saw the deceased alive on <u>8-11-1967</u> , and that death occurred at <u>1:16 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Jose M. De Leon</u> M.D. | | 22b. DATE SIGNED <u>8-11-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>JOSE M. DE LEON, M.D.</u> | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>August 14, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>FRIENDS BURIAL GROUNDS</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>Wm Cook-Brooks Towson</u> | | 25a. REC'D BY REGISTRAR <u>1050 York Rd Towson, Md 21204</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | DATE <u>AUG 14 1967</u> | |

FOR STATE
HEALTH DEPT.

EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A/SM (5)
SM 1/65

| <div> <div>1</div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>10567</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>10567</div> </div> | | | | | | | | | | | |
|--|--|-------------------------------------|--|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point | | | | c. LENGTH OF STAY IN 1b | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Plant Dispensary | | | | d. STREET ADDRESS 3820 Elmley Avenue #13 | | | | a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Martin Middle Joseph Last COSGROVE Jr. | | | | 4. DATE OF DEATH Month Aug Day 15 Year 67 | | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6-10-17 | | 9. AGE (In years last birthday) 50 yrs | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | | | 10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Making | | 11. BIRTHPLACE (State or foreign country) Balto., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Martin J. Cosgrove Sr. | | | | | | 14. MOTHER'S MAIDEN NAME Mary Stanford | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | | | | 16. SOCIAL SECURITY NO. 216-10-9041 | | 17. INFORMANT Mary Cosgrove, wife, above | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A.S.C.V. Disease 4-1-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 0 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) X | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) E | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Melvin B. Davis | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 22. DATE SIGNED 8-15-67 | | | |
| EXAMINER'S NAME (Type) Melvin B. Davis, M.D. 6800 Morningside Rd. Dundalk, Md. 21222 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/18/67 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery | | | | 23d. LOCATION (City, town or county) (State) Balto., Md. | | | |
| 24. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane #13 | | | | | | 25a. REC'D BY REGISTRAR AUG 17 1967 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |



10568

CERTIFICATE OF DEATH

10568

| | | | |
|--|---------------------------------|--|---------------------------------------|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTA</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN</u> | | c. LENGTH OF STAY IN 1b <u>WOODLAWN</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>17 GWYNN LAKE DR</u> | | d. STREET ADDRESS <u>17 GWYNN LAKE DR</u> | |
| 3 NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>H.</u> Last <u>COUNCILL</u> | | 4 DATE OF DEATH Month <u>Aug</u> Day <u>30</u> Year <u>1967</u> | |
| 5 SEX <u>MALE</u> | 6 COLOR OR RACE <u>White</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>10-11, 1899</u> |
| 9. AGE (In years last birthday) <u>67</u> YRS | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | | 13. FATHER'S NAME <u>Wm B. Councill</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Roe</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWI-NAVY</u> | |
| 16. SOCIAL SECURITY NO. <u>218-32-3356</u> | | 17. INFORMANT <u>Ruth S. Councill - Same</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Disease</u> DUE TO (b) <u>- Recurrent Carcinoma of Larynx</u> DUE TO (c) <u>-</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>- 2 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | 19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug - 13, 1966</u> to <u>Aug 30, 1967</u> , that (I) (<u>yes</u>) last saw the deceased alive on <u>Aug 5, 1967</u> , and that death occurred at <u>2:30 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Earl L. Chambers</u> | | 22b. DATE SIGNED <u>9/1/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u> | | 22d. ADDRESS <u>4108 Liberty Hts Balto. Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>9-2-67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>London Park Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>BALTA, MD</u> | |
| 24. FUNERAL DIRECTOR <u>Ellsworth Armacost</u> | | 25a. REC'D BY REGISTRAR <u>SEP 5 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> </div> <div> <p>10569</p> <p>Item #23, c & d - 11-11-67</p> </div> <div> <p>10569</p> </div> </div> | | | | | | | | | | | | | | |
|---|--|--|---|--|--|--|--|---|---|--|--|---|---|--|
| <p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Baltimore</u> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u></p> <p>c. LENGTH OF STAY IN 1b</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forleigh Nursing Home</u></p> | | | | | | <p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <u>New Hampshire</u> b. COUNTY <u></u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u></p> <p>d. STREET ADDRESS <u>402 Laurel St.</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> | | | | | | | | |
| <p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>Catherine</u> Middle <u></u> Last <u>Creamer</u></p> | | | <p>4. DATE OF DEATH</p> <p>Month <u>August</u> Day <u>10</u> Year <u>1967</u></p> | | | <p>5. SEX <u>Female</u></p> | | | <p>6. COLOR OR RACE <u>White</u></p> | | | <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/></p> | | |
| <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><u>Telephone - Supervisor</u></p> | | | <p>10b. KIND OF BUSINESS OR INDUSTRY</p> | | | <p>11. BIRTHPLACE (County & State, or foreign country)</p> <p><u>Baltimore, Md.</u></p> | | | <p>12. CITIZEN OF WHAT COUNTRY?</p> | | | <p>8. DATE OF BIRTH</p> <p><u>June 2, 1890</u></p> | | |
| <p>13. FATHER'S NAME</p> <p><u>Henry Creamer</u></p> | | | <p>14. MOTHER'S MAIDEN NAME</p> <p><u>Mary Frances Hightaffei</u></p> | | | <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u></p> | | | <p>16. SOCIAL SECURITY NO.</p> | | | <p>17. INFORMANT Address</p> | | |
| <p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u></p> <p>331X DUE TO (b) <u>Arteriosclerosis</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u></p> | | | | | | | | | | | <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><u>7 days</u></p> <p><u>unknown</u></p> | | | |
| <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p> <p><u>Arteriosclerotic Heart Disease</u></p> | | | | | | | | | | | | | <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> | |
| <p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> | | | | | | <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p> | | | | | | | | |
| <p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour <u>a.m.</u> <u>19</u> p.m.</p> | | | | <p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> | | <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> | | <p>20f. (City or town) (County) (State)</p> | | | | | | |
| <p>21. I certify that (1) this hospital attended the deceased from <u>7-11</u>, 19<u>67</u>, to <u>8-10</u>, 19<u>67</u>, that (1) (we) last saw the deceased alive on <u>8-10</u>, 19<u>67</u>, and that death occurred at <u>11:15 AM</u>, from the causes and on the date stated above.</p> | | | | | | | | | | | | | | |
| <p>22a. SIGNATURE <u>David I. Miller</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p> | | | | | | | | | | | <p>22b. DATE SIGNED <u>8-10-67</u></p> | | | |
| <p>22c. PHYSICIAN'S NAME (Type) <u>David I. Miller</u></p> | | | | | | <p>22d. ADDRESS <u>Loudon Rd. Owings Mills, Md</u></p> | | | | | | | | |
| <p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u></p> | | | <p>23b. DATE THEREOF <u>8/12/67</u></p> | | <p>23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u></p> | | | <p>23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u></p> | | | | | | |
| <p>24. FUNERAL DIRECTOR <u>William J. Dickner & Sons North & Emma</u></p> | | | | | | <p>25a. REC'D BY REGISTRAR <u>DATE AUG 15 1967</u></p> | | | <p>25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u></p> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10570

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk | | | |
| c. LENGTH OF STAY IN 1b 20 years | | | | d. STREET ADDRESS 7009 Railway Avenue | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6800 Mornington Road | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Walter Middle G. Last Critzman | | | | 4. DATE OF DEATH Month August Day 3 Year 1967 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 27-1904 | |
| 9. AGE (In years last birthday) 63 yrs. | | IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min. | | IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Weigher | | | | 10b. KIND OF BUSINESS OR INDUSTRY American Smelting & | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME William G. Critzman | | | | 14. MOTHER'S MAIDEN NAME Anna Greenwauld | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16. SOCIAL SECURITY NO. 212-10-1536 | | 17. INFORMANT Sister, Mrs. Edna Schoepflin, #2, a, b, c, d. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC HEART DISEASE DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | INTERVAL BETWEEN ONSET AND DEATH 2-3 YRS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from JUNE 27, 1967 to AUG 3, 1967 , that (I) (we) last saw the deceased alive on AUG 3 1967 , and that death occurred at 9:45 AM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Melvin B. Davis | | | | 22b. DATE SIGNED August-5-1967 | | 22c. PHYSICIAN'S NAME (Type) Melvin B. Davis M.D. | |
| 22d. ADDRESS 6800 Mornington Rd. Dundalk, Md. 21222 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF August-7-1967 | | 23c. NAME OF CEMETERY OR CREMATORY St. Paul's | | 23d. LOCATION (City, town or county) (State) Baltimore, Maryland 21224 | |
| 24. FUNERAL DIRECTOR JOHN J. DUDA, Dundalk, Maryland 21222 | | | | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10571

| | | | | | | | |
|---|-------------------------------|--|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL BALTIMORE c. LENGTH OF STAY IN 1b 11 YEARS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9702 OAKDALE AVE | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL BALTIMORE 21234 d. STREET ADDRESS 9702 OAKDALE AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) FRED | | First DEFOREST Middle CROSBY Last | | 4. DATE OF DEATH AUGUST 27 1967 | | | |
| 5. SEX M | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH APRIL 19, 1902 | 9. AGE (In years last birthday) 65 yrs. | IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COMMISSIONER AMATEUR WORKS. | | 10b. KIND OF BUSINESS OR INDUSTRY EDUCATION | | 11. BIRTHPLACE (County & State, or foreign country) ONTARIO NEW YORK | | | |
| 13. FATHER'S NAME WILLIAM CROSBY | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO. 1943-1946 | | 17. INFORMANT WIFE Address 9702 OAKDALE AVE | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SMALL CELL CARCINOMA OF LUNG. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS. | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from 1965 , to AUG 27, 1967 , that (I) (we) last saw the deceased alive on AUG 22 1967 , and that death occurred at 3:04 M. from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Samuel I O'Mansky | | 22b. DATE SIGNED Aug 27 1967 | | 22c. PHYSICIAN'S NAME (Type) SAMUEL I O'MANSKY | | | |
| 22d. ADDRESS P 23 York Road Blvd. | | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 9/1/67. | | 23c. NAME OF CEMETERY OR CREMATORY Resthaven Cemetery | | | |
| 23d. LOCATION (City, town or county) (State) Phelps, New York. | | 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 ADDRESS | | | | | |
| 25a. REC'D BY REGISTRAR AUG 28 1967 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | | |

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10572

10572

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|---------------------------------|---|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| c. LENGTH OF STAY IN 1b St. Joseph's Hospital | | d. STREET ADDRESS 1228 N. 62nd St. | |
| 3 NAME OF DECEASED (Type or print) EVELYN IDA CROUSE | | 4 DATE OF DEATH Month August Day 15 Year 1967 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8 AGE (In years last birthday) 42 yrs |
| 9 BIRTHPLACE (State or foreign country) Maryland | | 10 CITIZEN OF WHAT COUNTRY? USA | |
| 11 BIRTHPLACE (State or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13 FATHER'S NAME William Litz | | 14 MOTHER'S MAIDEN NAME Wynona Myers | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) no | | 16 SOCIAL SECURITY NO 219 22 5350 | |
| 17 INFORMANT Charles M. Litz | | Address 400 Avery St. Joppa, Md. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Pulmonary Embolism complicating Multiple Injuries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20c TIME OF INJURY Month, Day, Year UNK p.m. 8/6 19 67 | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Subj. in auto accident 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street | |
| 20f (City or town) Baltimore, Md. | | 20g (County) _____ (State) _____ | |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from. Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Werner U. Spitz, M.D. | | 22. DATE SIGNED 8/15/67 | |
| EXAMINER'S NAME (Type) Werner U. Spitz | | Address (Street, city, town, or county) 1211 Chesebro Ave. | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE THEREOF Aug. 19, 1967 | |
| 23c NAME OF CEMETERY OR CREMATORY Brooklands of Faith Cemetery | | 23d LOCATION (City or town) (County) (State) Baltimore, Md. | |
| 24 FUNERAL DIRECTOR Philip E. Crach | | 25a RECD BY REGISTRAR AUG 17 1967 | |
| 25b REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 10573 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 10573 | |
|--|--|---|-----------------|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Harold | Middle M. | Last Cummins, Sr. | 2a. DATE OF DEATH Month Day Year Aug. 18, 1967 | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH July 19, 1898 | | 6. AGE (In years last birthday) 69 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | |
| 1d. CITY OR TOWN OF DEATH Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dulaney Valley Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired - Building Contractor | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE Maryland | | 13b. COUNTY -- | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last Robert P. Cummins | | 15. MOTHER'S MAIDEN NAME First Middle Last Maryl E. Macneal | | 13e. STREET AND NUMBER 12 W. 24th Street #18 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | (If yes give year or dates of service) | | 16b. SOCIAL SECURITY NO 212-01-2108 | | 17. INFORMANT Mrs. Irma C. Cummins Address 12 W. 24th St. 18 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of tongue with metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>None</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2. Item 18) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 30, 1967</u> to <u>Aug. 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>August 18, 1967</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>L. Myrton E. Gines Jr.</u> | | 22c. DATE SIGNED <u>3/19/68</u> | | 22d. PHYSICIAN'S NAME (Type) <u>L. Myrton E. Gines Jr.</u> | | | |
| 22e. ADDRESS <u>7800 York Rd. - Towson, Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>8/21/1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Woodlawn, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Wm. J. Tickner & Sons</u> | | ADDRESS <u>North & Pa. Balto. Md.</u> | | 25a. REC'D BY REGISTRAR <u>Jul 24, 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | |



CERTIFICATE OF DEATH

10574

10574

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY — | |
| c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21218 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | d. STREET ADDRESS 510 E. 39th St. | |
| 3 NAME OF DECEASED (Type or print) First Nellie Middle A. Last CURRAN | | 4. DATE OF DEATH Month August Day 15 Year 19 67 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH July 31, 1886 |
| 9 AGE (In years last birthday) 81 yrs | | IF UNDER 1 YEAR Months — Days — Hours — Min. — | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) New Jersey | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13 FATHER'S NAME Michael Kenny | | 14 MOTHER'S MAIDEN NAME Catherine Morrison | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. | |
| 17 INFORMANT Mrs. Charles C. Doud | | Address Same | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute gastro intestinal hemorrhage cause undetermined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis, acute (c) Generalized arteriosclerosis. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS A. TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 8, 19 67 , to August 15, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 15, 19 67 , and that death occurred at 9:45M , from causes and on the date stated above. | | | |
| 22. SIGNATURE Teodula Paglinauan, Jr. M.D. | | 22b. DATE SIGNED August 15, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Teodula Paglinauan, Jr., M.D. | | 22d. ADDRESS 7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8-18-67 | 23c. NAME OF CEMETERY OR CREMATORY New Cayhedral | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md |
| 24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. | | 25a. REC'D BY REGISTRAR Charles Judge | |
| 6500 York Rd. Baltimore, Md. 21212 | | DATE AUG 21 1967 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10575
CERTIFICATE OF DEATH
10575

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN b. 2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Forest Haven Nursing Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Frederick First Middle Last | | 4. DATE OF DEATH 8 Month 2 Day 1967 Year | |
| 5. SEX Male | | 6. COLOR OR RACE White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11-26-86 | |
| 9. AGE (In years last birthday) 80 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ICE-MAN | | 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME UNKNOWN | | 14. MOTHER'S MAIDEN NAME UNKNOWN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. 218-18-3338 | |
| 17. INFORMANT WALTER C. RICHWINE Address 2912 MONTEBELLO TERR | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial - Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arterio Sclerotic CAD - Uncontrolled DUE TO (c) Dysrhythm | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 6/22 , 19 66 , to 8/2 , 19 67 , that (I) (we) last saw the deceased alive on 8/1 , 19 67 , and that death occurred at 6 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE John H. Shaw | | 22b. DATE SIGNED 8/2/67 | |
| 22c. PHYSICIAN'S NAME (Type) JOHN H. SHAW | | 22d. ADDRESS 5700 ELEANOR AVE | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 7/5/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY MORELAND CEM. | | 23d. LOCATION (City, town or county) (State) BALTO, MD. | |
| 24. FUNERAL DIRECTOR Robert C. Williams Address 6009 Harford Rd. | | 25a. REC'D BY REGISTRAR AUG 7 1967 25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | |

10576

CERTIFICATE OF DEATH

10576

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|---|--|---|--|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD. b. COUNTY Baltimore | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson | | c. LENGTH OF STAY IN 1b 14 months 10 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital | | | d. STREET ADDRESS 2249 Sidney Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3 NAME OF DECEASED (Type or print) First FRANKLIN DANIEL Middle DAVIS Last DAVIS | | | 4. DATE OF DEATH Month 8 / Day 27 / Year 1967 | | |
| 5 SEX M | 6. COLOR OR RACE W. | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 5/11/90 | | 9. AGE (In years last birthday) 77 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mail carrier | | 10b. KIND OF BUSINESS OR INDUSTRY RETIRED | | 11 BIRTHPLACE (County & State, or foreign country) West Virginia | |
| 13. FATHER'S NAME Daniel Davis | | | 14. MOTHER'S MAIDEN NAME Ida Randolph | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO 23 5-54-208 | | 17. INFORMANT Address Records, Mt. Wilson State Hospital | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 years |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic obstructive airway disease, severe | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 6/17/1967 to 8/27/1967 , that (I) (we) last saw the deceased alive on 8/27/1967 , and that death occurred at 11:15 AM , from causes and on the date stated above. | | | | | |
| 22a SIGNATURE W. Newcomer | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 8.28.1967 | |
| 22c PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Supt. | | 22d. ADDRESS Mt. Wilson, Maryland | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b DATE THEREOF 8/30/67. | 23c NAME OF CEMETERY OR CREMATORY Marshville Baptist Cemetery | | 23d. LOCATION (City or Town) (County) (State) Marshville, W. Va. | |
| 24 FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | ADDRESS 25a. REC'D BY REGISTRAR DATE AUG 28 1967 | | 25b REGISTRAR'S SIGNATURE Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10577

CERTIFICATE OF DEATH

10577

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN It 35 4 | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY #21212 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 903 Woodburn Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Caroline Elizabeth Dibble | | 4. DATE OF DEATH Month August Day 1 Year 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH September 29, 1877 |
| 9. AGE (In years lost birthday) 89 yrs | | 10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1967 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (County & State, or foreign country) Gamber, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Lindsay | | 14. MOTHER'S MAIDEN NAME Martha Ogg | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Luther L. Dibble | | Address 807 Evesham Ave | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE (DECOMPENSATED) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) 7200 (c) 7200 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 7200 | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from July 30 1967 to August 1 , 1967, that (I) (we) last saw the deceased alive on August 1 1967, and that death occurred at 12:15 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE Ramon P. Lopez | | 22b. DATE SIGNED August 1, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Ramon P. Lopez, M.D. | | 22d. ADDRESS 7620 York Road | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF Aug 4, 1967 | 23c. NAME OF CEMETERY OR CREMATORY Westminster Cem. | 23d. LOCATION (City or Town) (County) (State) Carroll Co. Md |
| 24. FUNERAL DIRECTOR BURQUEE FUNERAL HOME | | 25a. RECD BY REGISTRAR Charles Judge | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | DATE AUG 4 1967 | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

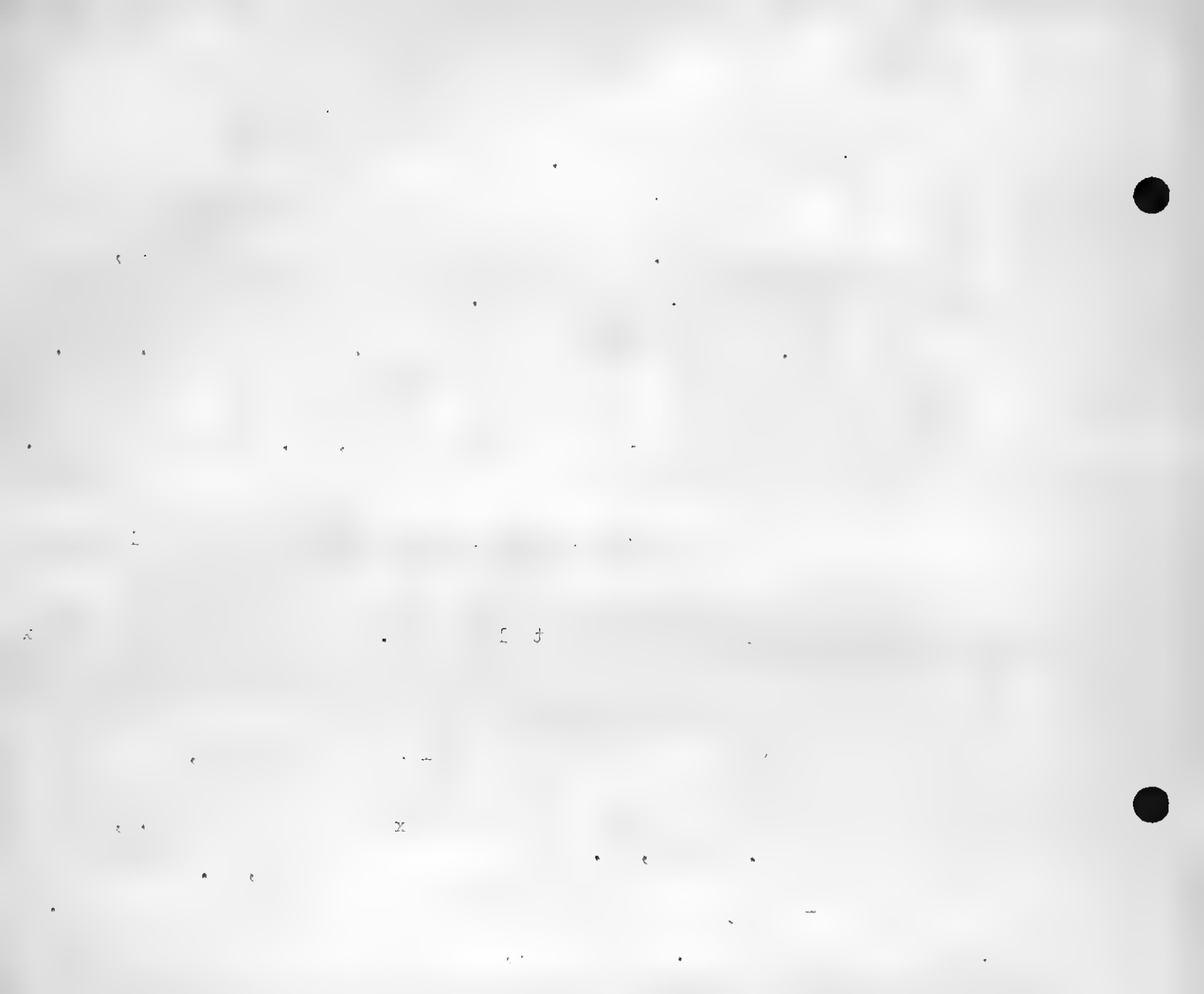
| <div> <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> </div> <div> <div> <div>10578</div> <div>10578</div> </div> <div> <div>10578</div> <div>10578</div> </div> </div> | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| <div> <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> </div> <div> <div> <div>10578</div> <div>10578</div> </div> <div> <div>10578</div> <div>10578</div> </div> </div> | | | | | | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | |
| <div> <div>1</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div>07/13/67</div> </div> | | | | | <div> <div>2</div> <div>20a b, c</div> <div>592</div> </div> <div> <div>20a b, c</div> <div>592</div> <div></div></div> | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 10579 | | | | | | | | | |
|--|--|-------------------------------|--|--|---|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 2 Wks. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shangri-La Nursing Home | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 5219 Windsor Mill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First Walter M. Middle Disney Last Disney | | | | | 4. DATE OF DEATH Month August Day 30 Year 1967 | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Mar. 29, 1878 | | 9. AGE (In years last birthday) 89 yrs. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bottling Dept. | | | 10b. KIND OF BUSINESS OR INDUSTRY Royal Farm Dairy | | | 11. BIRTHPLACE (County & State, or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Nelson Kellogg Disney | | | | | 14. MOTHER'S MAIDEN NAME Georgeanna Stephen | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | 16. SOCIAL SECURITY NO. 215-09-2405 | | 17. INFORMANT Address Marvin Disney, Sr. 1647 Langford Rd. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe varicose ulcerations over both lower legs. | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 hours 10 years |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) this doctor attended the deceased from August 16, 1967 to August 30, 1967 , that (I) was last saw the deceased alive on August 30, 1967 , and that death occurred at 8:30 PM , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <i>Willard T. Traband, Jr.</i> | | | | | M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED Sept. 1, 1967 | | |
| 22c. PHYSICIAN'S NAME (Type) Willard T. Traband, Jr. | | | | | 22d. ADDRESS 1811 North Rolling Road, Baltimore, Md. 21207 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF 9-2-1967 | | 23c. NAME OF CEMETERY OR CREMATORY Pleasant Hill | | 23d. LOCATION (City, town or county) (State) Baltimore, Md. | | |
| 24. FUNERAL DIRECTOR ADDRESS G. Howard Strong 3207 W. North Ave., | | | | | 25a. REC'D BY REGISTRAR DATE SEP 5 1967 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | |



CERTIFICATE OF DEATH

10580

1 (M)

10580

1. NAME OF DECEASED
(Type or Print)

William W. Dixon

2. DATE AND HOUR OF DEATH

August 22, 1967

5:45 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

BALTIMORE COUNTY

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

BALTIMORE - 29

638 North Bend Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

BALTIMORE

C. CITY OR TOWN

(If outside city limits, write RURAL and give township)

Baltimore - 29

D. STREET ADDRESS

(If rural, give location)

638 North Bend Road

5. SEX

M

6. RACE

Cauc.

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Sept. 29/90

76

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Samuel Dixon

14. MOTHER'S MAIDEN NAME

Mary Crow

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs. Marie White

638 North Bend Rd.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

(B) DUE TO

(C) DUE TO

24 hrs.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

22. I certify that (I) (this hospital) attended the deceased from 1-13-1960 to 8-22-1967

that (I) (we) last saw the deceased alive on 8-22-1967 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

8-23-67

23C. PHYSICIAN'S
NAME (Type)

Harry L. Knipp

M.D.

23D. ADDRESS

4116 Edmondson Ave.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

8/25/67

24C. NAME of CEMETERY or CREMATORY

Woodlawn Cem.

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE RECEIVED BY HEALTH DEPT.

AUG 29 1967

25B. NAME OF REGISTRAR

Charles Judge

25C. FUNERAL DIRECTOR

Witzke F. D. - 4101 Edmondson Ave.

ADDRESS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove funeral papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial cremation or removal.

10581

CERTIFICATE OF DEATH

10581

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|----------------------------------|---|--------------------------------------|
| 1 PLACE OF DEATH a COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b COUNTY Balto. | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baynesville | | c LENGTH OF STAY IN lb 1yr. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6625 Wycombe Way | | d STREET ADDRESS 6625 Wycombe Way 12 | |
| 3. NAME OF DECEASED (Type or print) Agnes K. Doyle | | 4 DATE OF DEATH Month 8 Day 18 Year 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-18-1890 |
| 9. AGE (In years last birthday) 77 yrs | | 10. IF UNDER 1 YEAR Months 18 Days 18 Hours 18 Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b KIND OF BUSINESS OR INDUSTRY Housewife | |
| 11 BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Rolfe | | 14. MOTHER'S MAIDEN NAME Elizabeth Gill | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | 16 SOCIAL SECURITY NO. 212-22-6266 | |
| 17. INFORMANT Mr Joseph C. Doyle | | Address 105 Elinor Avenue 36 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) hypertension and Terminal CVA | | INTERVAL BETWEEN ONSET AND DEATH Undet. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Murdered Obesity. | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 19, 1967 , to 8-18, 1967 , that (I) (we) last saw the deceased alive on July 27, 1967 , and that death occurred at 6:05 p.m. from causes on the date stated above. | | | |
| 22a. SIGNATURE John C. Hyle | | 22b. DATE SIGNED 8-19-67 | |
| 22c. PHYSICIAN'S NAME (Type) JOHN C. Hyle | | 22d. ADDRESS 7527 Belair Rd Balt 36 Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8-21-1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Moreland Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md. | |
| 24. FUNERAL DIRECTOR Lassahn Funeral Home | | 25a REC'D BY REGISTRAR AUG 21 1967 | |
| ADDRESS 36 7401 Belair Rd | | 25b REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #236 File #314 3/1/67

10582

CERTIFICATE OF DEATH

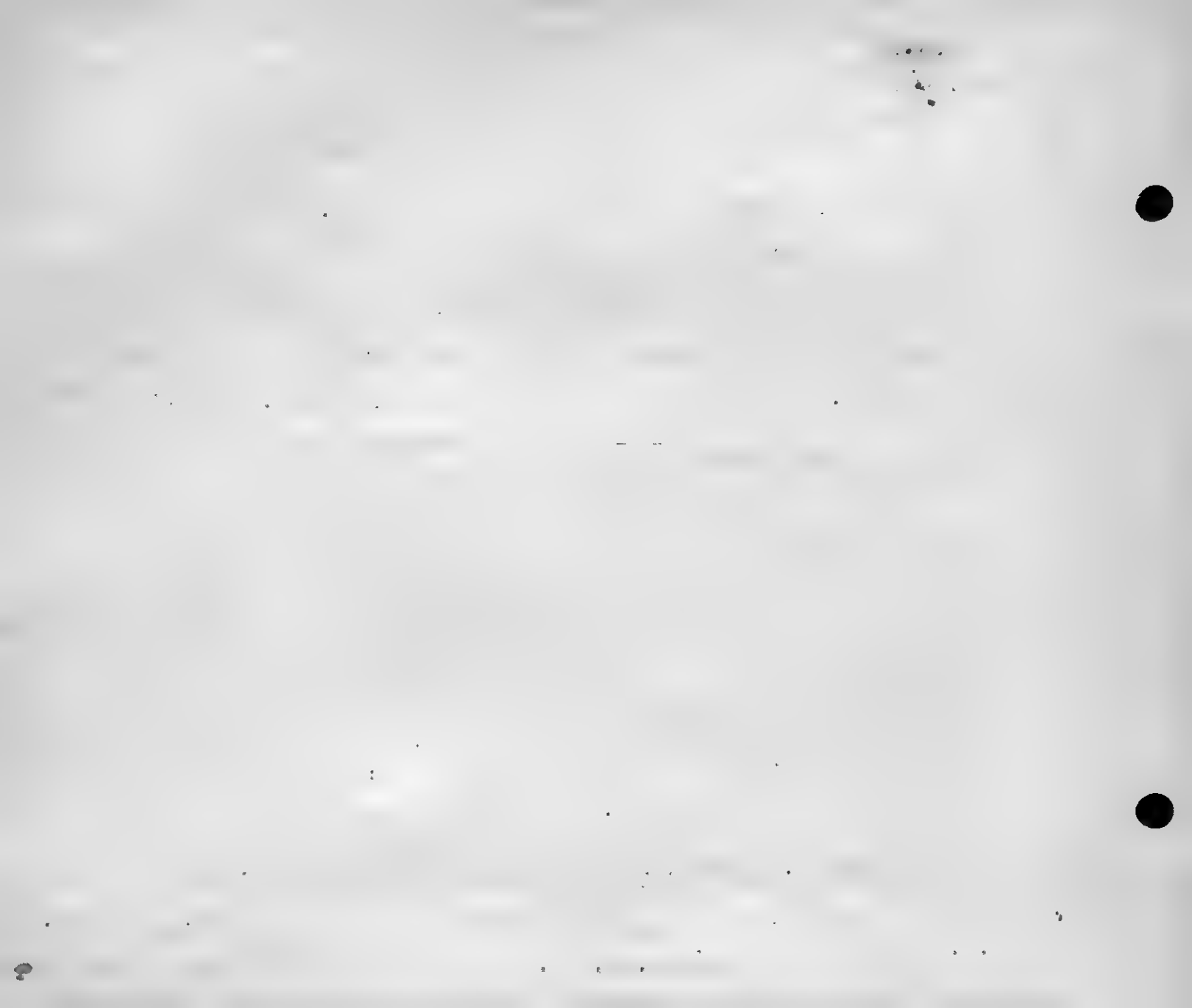
10582

| | | | | | | | |
|--|------------------------------|---|----------------------------------|---|---|---|--|
| 1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN 1b 9 DAYS | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | | | d. STREET ADDRESS 906 NORTH EDEN ST. BALTIMORE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) SULLIVAN | | First Middle Last NMI DUCREE | | 4. DATE OF DEATH AUGUST 1 19 67 | | Month MD. Day Year | |
| 5 SEX MALE | 6 COLOR OR RACE NEGRO | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/22/96 | | 9. AGE (In years lost birthday) 70 yrs | | IF UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PORTER | | 10b. KIND OF BUSINESS OR INDUSTRY RACE TRACK | | 11. BIRTHPLACE (County & State, or foreign country) NEW ORLEANS, LA. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME THOMAS DUCREE | | | | 14. MOTHER'S MAIDEN NAME FRANCES (UNKNOWN) | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I | | 16. SOCIAL SECURITY NO 437 07 50 79 | | 17. INFORMANT CLINICAL RECORDS VAH FORT HOWARD, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH DAYS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) MULTIPLE PULMONARY EMBOLI | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from JULY 23, 19 67 , to AUGUST 1, 19 67 that (I) (we) last saw the deceased alive on AUGUST 1, 19 67 and that death occurred 11:20 AM from causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE J. D. Talbert | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D. | | | | 22d. ADDRESS VAH FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 8/4/67 | | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY BALTIMORE MARYLAND | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR JOE KNIGHT FUNERAL HOME | | | | ADDRESS 1639 BROADWAY | | 25a. REC'D BY REGISTRAR AUG 3 1967 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |
| BALTIMORE, MARYLAND | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---------------------------|---|--|---|--|--------------------------------------|---|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 10583 CERTIFICATE OF DEATH 10583 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 16 5 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Stella Maris Hospice | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3100 St. Paul St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 3. NAME OF DECEASED (Type or print) Marie Celeste Duffy First Middle Last | | | | | 4. DATE OF DEATH 8/24/67 Month Day Year | | | | | | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5/18/91 | | 9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady | | | 10b. KIND OF BUSINESS OR INDUSTRY Tuerkes | | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME John J. Duffy | | | | | 14. MOTHER'S MAIDEN NAME Armanda R. Duffy (Nee Sedicum) | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16. SOCIAL SECURITY NO 217-05-2161 | | | 17. INFORMANT Hospice records | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO ASCVD Conditions, if any, which gave rise to immediate cause (b) ASCVD (a), stating the underlying cause last, DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 5/11/62 , 19 to 8/24/67 , 19, that (I) (we) last saw the deceased alive on 8/22/67 , 19, and that death occurred at 8:15A from the causes and on the date stated above | | | | | | | | | | 22b. DATE SIGNED 8/24/67 | |
| 22a. SIGNATURE Robert J. Mahon | | | | | 22c. PHYSICIAN'S NAME (Type) Robert J. Mahon, M.D. | | | | | 22d. ADDRESS 204 E/ Joppa Rd., Towson | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF 8/26/1967 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | | | 23d. LOCATION (City, town or county) (State) Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto. 12, Md. | | | | | | | | | | 25a. REC'D BY REGISTRAR AUG 24 1967 25b. REGISTRAR'S SIGNATURE Charles Judge | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10584

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial, transmittal permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River | | c. LENGTH OF STAY IN lb. 02/1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS 5 B. Byway South | |
| 3. NAME OF DECEASED (Type or print) First JAMES Middle R Last EVERETT | | 4. DATE OF DEATH Month August Day 16 Year 1967 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH MAR 15, 1915 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER | | 11. BIRTHPLACE (State or foreign country) W. VA. | |
| 13. FATHER'S NAME JOHN L. EVERETT | | 14. MOTHER'S MAIDEN NAME SALLY WEBER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNK | | 16. SOCIAL SECURITY NO. 214-07-452 | |
| 17. INFORMANT JAMES L. EVERETT | | Address 5 B. BYWAY S | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable gunshot wound of head 116X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Probably shot self | |
| 20c. TIME OF INJURY Month, Day, Year ? ? 19 | 20d. NATURE OF INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> or work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) woods | 20f. (City or town) (County) (State) Middle River BALTIMORE MD. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles S. Springate M.D. | | 22. DATE SIGNED September 1, 1967 | |
| EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | Address (Street, city, town, or county) | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF SEPT. 9, 1967 | 23c. NAME OF CEMETERY OR CREMATORY BEL AIR CEM | 23d. LOCATION (City or Town) (County) (State) BEL AIR MD |
| 24. FUNERAL DIRECTOR J.G. CONNELLY SONS | | 25a. REC'D BY REGISTRAR SEP 11 1967 | |
| ADDRESS 300 MACE | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

100



10585

CERTIFICATE OF DEATH

10585

| | | | | | |
|--|--|--|--|---|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c LENGTH OF STAY IN 1b 12 Days | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital | | | d STREET ADDRESS 3413 O'Donnell Street | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3 NAME OF DECEASED (Type or print) First Middle Last GEORGE WILLIAM FIELDS | | | 4 DATE OF DEATH Month Day Year AUGUST 30 1967 | | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 5/2/93 | | 9 AGE (In years last birthday) yrs. 74 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard | | 10b. KIND OF BUSINESS OR INDUSTRY Crown, Cork & Seal Co. | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland | |
| 13. FATHER'S NAME William Fields | | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I | | | 16. SOCIAL SECURITY NO. 215-05-54-50 | | 17. INFORMANT Address Clin. Rec. VA Hospital, Fort Howard, Md. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS, ACUTE DUE TO (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH YEARS |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS. ARTERIOGLOMERULOSCLEROSIS | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 18, 1967 , to August 30, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 30, 1967 , and that death occurred at 5:30 AM from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <i>George Dudas</i> | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 8/30/67 |
| 22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D. | | | 22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF Sept. 2, 1967 | 23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem. | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR ADDRESS BERNARD DABROWSKI FUNERAL HOME | | | 25a. REC'D BY REGISTRAR DATE SEP 6 1967 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|--|---|--|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 10588 | | | | | | | | | |
| 10586 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson, 21204 c. LENGTH OF STAY IN 1b 4 months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Towson Convalescent Home | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cockeysville, Maryland 21030 d. STREET ADDRESS Oak Knoll Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First Annie Laura Middle Fink Last Fink | | | | | 4. DATE OF DEATH Month August Day 22 Year 1967 | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8 March 1883 | | 9. AGE (in years last birthday) 84 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore County, Md. | | 12. CITIZEN OF WHAT COUNTRY? United States | | | |
| 13. FATHER'S NAME Nelson Frederick | | | | | 14. MOTHER'S MAIDEN NAME Mary Garrett Frederick | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 220-30-5446 | | 17. INFORMANT Address Mrs. June Good, Daughter Same | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma DUE TO (b) 10 + 1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 months |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21. I certify that (I) (this hospital) attended the deceased from 1963 , to August , 1967, that (I) (we) last saw the deceased alive on 21 August 1967, and that death occurred at 10A.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Walter T. Kees | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 22 August 1967 | | |
| 22c. PHYSICIAN'S NAME (Type) Walter T. Kees, M. D. | | | | | 22d. ADDRESS Cockeysville, Maryland 21030 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF Aug. 25, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY | | 23d. LOCATION (City, town or county) (State) PARKVILLE, MD. | | | |
| 24. FUNERAL DIRECTOR John Burns Sons, Towson, Md. | | | | | 25a. REC'D BY REGISTRAR AUG 29 1967 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

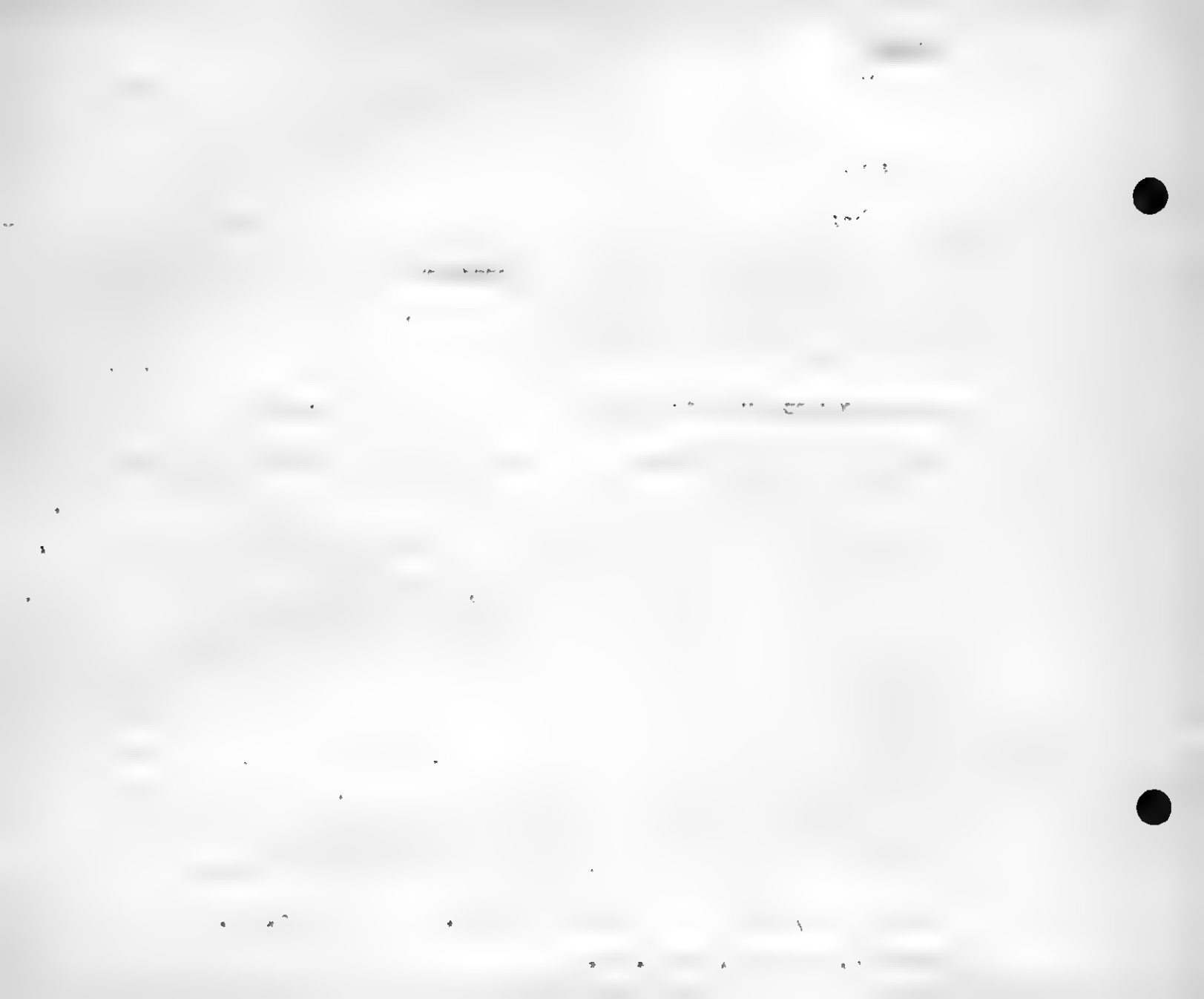
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10587

CERTIFICATE OF DEATH

10587

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY --- | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c LENGTH OF STAY IN lb 1yr7mth23dys | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospito, give street address) SPRING GROVE STATE HOSPITAL | | e STREET ADDRESS 3533 Wilkens Avenue | |
| 3. NAME OF DECEASED (Type or print) Minnie (Fischer) | | 4. DATE OF DEATH Month August Day 22 Year 19 67 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 6, 1886 |
| 9. AGE (In years last birthday) 81 yrs | | 10. IF UNDER 1 YEAR Months --- Days --- Hours --- Min --- | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME Frederick Reuwer | | 14. MOTHER'S MAIDEN NAME Elizabeth Smith | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arteriosclerotic cardiovascular heart dis 1 yr. DUE TO (c) Arteriosclerosis, generalized, senile 10 yrs. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none | | | |
| 19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH 1 yr. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) | 20f. (City or town) (County) (State) |
| 21. I certify that (P) (this hospital) attended the deceased from Dec. 29, 1955 to Aug. 22, 1967 , that (P) (we) last saw the deceased alive on Aug. 22, 1967 , and that death occurred at 4:30 M, from causes and on the date stated above | | | |
| 22a. SIGNATURE Anthony J. Young, M.D. | | 22b. DATE SIGNED 8-23-67 | |
| 22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D. | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/26/67 | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | 23d. LOCATION (City or Town) (County) (State) Balto, Md. |
| 24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. | | 25a. REC'D BY REGISTRAR DATE AUG 24 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



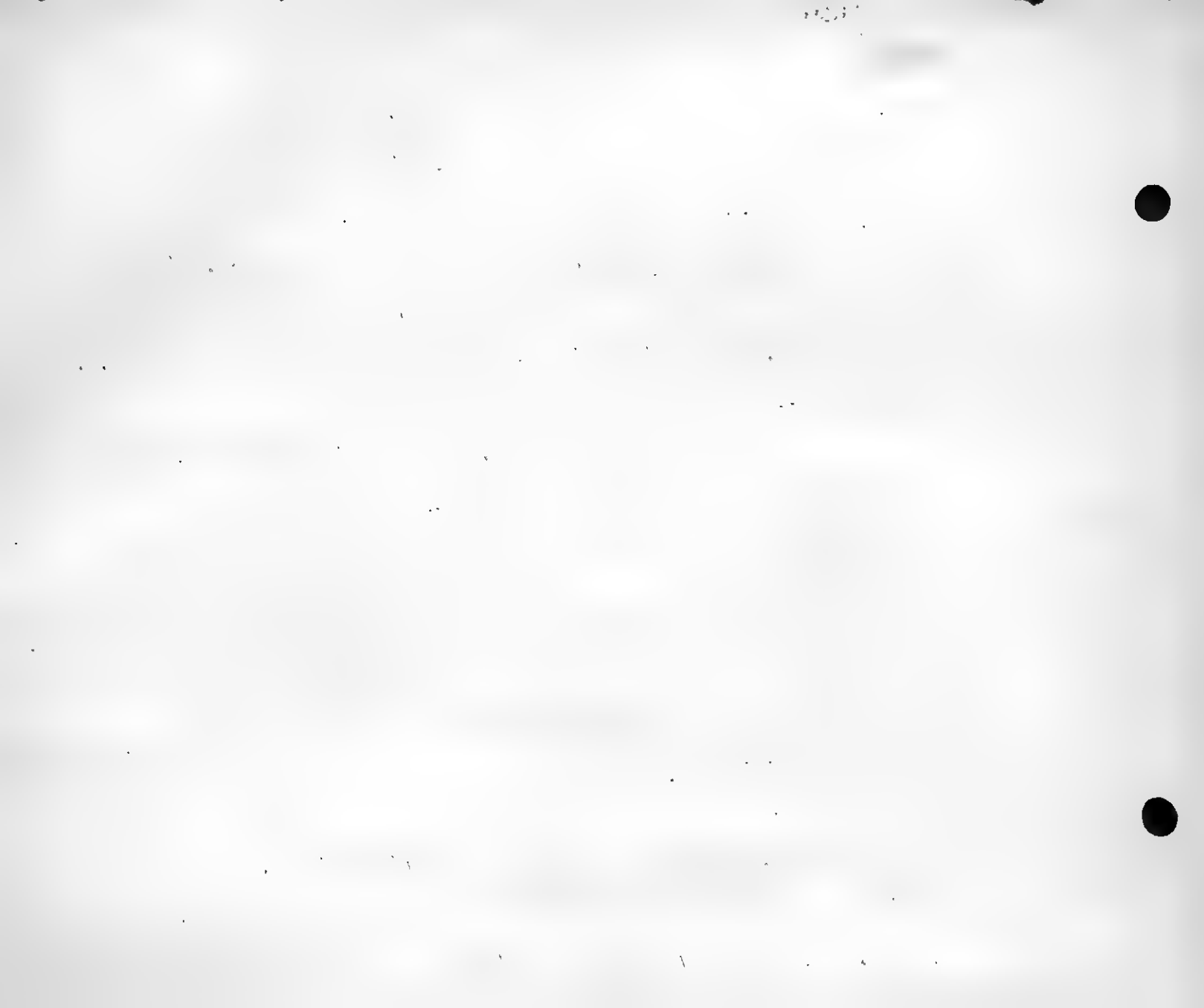
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> 10588 MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>4508 Forest View Avenue</i> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>10588</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> d. STREET ADDRESS <i>4508 Forest View Avenue</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <i>Harry A Fisher Sr.</i> | | 4. DATE OF DEATH Month <i>Aug.</i> Day <i>5</i> Year <i>1967</i> | | 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>White</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>Sept. 8, 1897</i> | | 9. AGE (In years last birthday) <i>69</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Printing Dept.</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>American Oil Co.</i> | | 11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore, Maryland</i> | | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | | |
| 13. FATHER'S NAME <i>Frank Fisher</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Anna Gephart</i> | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. <i>215-03-3838</i> | | 17. INFORMANT Address <i>Mrs. Ethel Naomi Fisher-4508 Forest View Ave</i> | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>carcinomatosis</i> (b) <i>Carcinoma of Stomach</i> (c) <i>6 months</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>1957</i> , to <i>8/5</i> , 1967, that (I) (we) last saw the deceased alive on <i>8/4</i> , 1967, and that death occurred at <i>12:30 AM</i> , from the causes and on the date stated above. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE <i>Paul G. Mueller</i> | | | | 22b. DATE SIGNED <i>8/5/67</i> | | | | 22c. PHYSICIAN'S NAME (Type) <i>Paul G. Mueller</i> | | | | 22d. ADDRESS <i>4311 Belair Rd.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF <i>8-8-67</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i> | | 23d. LOCATION (City, town or county) (State) <i>Balto. Md.</i> | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS <i>John C. Miller Inc-6415 Belair Rd.-21206</i> | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE <i>g Charles Judge</i> | | | | | | | |
| DATE <i>AUG 8 1967</i> | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10589

10589 -

| | | | |
|---|--|---|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson | | c. LENGTH OF STAY IN lb LINTAICUM AIRHTS, MD | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital | | d. STREET ADDRESS 507 LYMAN ST. | |
| 3 NAME OF DECEASED (Type or print) NADINE First LAVERA Middle FLANNERY Last | | 4. DATE OF DEATH Month 8 Day 27 Year 1967 | |
| 5. SEX FEMALE | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/21/13 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife Clerk (Dry-Cleaning) | | 10b. KIND OF BUSINESS OR INDUSTRY Dry-Cleaning | 9. AGE (In years last birthday) 54 yrs |
| 11. BIRTHPLACE (County & State, or foreign country) Indiana | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME HARVEY CLARK | | 14. MOTHER'S MAIDEN NAME MARY GRIMM | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO Unknown | |
| 17. INFORMANT Records, Mt. Wilson State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral spontaneous pneumothorax. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Pulmonary Emphysema. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 6 yrs | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour * o m. p m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 8/17/1967 to 8/25/1967 , that (I) (we) last saw the deceased alive on 8/27/1967 , and that death occurred at 5A. M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE W. Newcomer | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Supt. | | 22d. ADDRESS Mt. Wilson, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
| Burial | Aug. 31, 1967 | Cedar Hill Cem. | Brooklyn (RFD) Md. |
| 24. FUNERAL DIRECTOR R.W. Singleton Funeral Home | | 25a. REC'D BY REGISTRAR Glen Burnie, Md. | |
| 25b. REGISTRAR'S SIGNATURE John J. Judge | | 25c. DATE AUG 30 1967 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10590

10590

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 21yr1mth4dys | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | e. STREET ADDRESS 1622 Johns Street | |
| 3. NAME OF DECEASED (Type or print) Ruth V. Forbes | | 4. DATE OF DEATH Month August Day 9 Year 1967 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 18, 1883 9. AGE (In years last birthday) 83 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (Country & state or city & country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME Willard Owens | | 14. MOTHER'S MAIDEN NAME Leah Bussells | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. 214-18-5852J | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized Arteriosclerosis DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (A) (this hospital) attended the deceased from April 5, 1946 , to Aug. 9, 1967 , that (A) (we) last saw the deceased alive on Aug. 9, 1967 , and that death occurred on Aug. 9, 1967 , at 6:45 M., from causes and on the date stated above | | | |
| 22a. SIGNATURE Ramon A. Boza, M.D. | | 22b. DATE SIGNED 8-9-67 | |
| 22c. PHYSICIAN'S NAME (Type) Ramon A. Boza, M.D. | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/11/67 | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. |
| 24. FUNERAL DIRECTOR W. L. Lickens & Sons | | 25a. REC'D BY REGISTRAR Charles Judge | |
| ADDRESS Baltimore, Md. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |
| DATE AUG 9 1967 | | | |

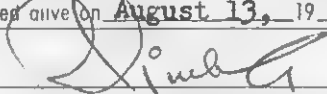

10591

CERTIFICATE OF DEATH

10591

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY — | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | d. STREET ADDRESS 514 N. Decker Ave. #21205 | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Emma A. Freburger | | 4. DATE OF DEATH Month Day Year August 13, 19 67 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-28-1884 |
| 9. AGE (in years last birthday) 83 yrs | | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Michael Esposito | | 14. MOTHER'S MAIDEN NAME Mary Trautner | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs. Edward Getz, 3531 Woodring Ave. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intra-cerebral hemorrhage. X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (1) (this hospital) attended the deceased from 8-12- , 19 67 , to 8-13- , 19 67 , that (1) (we) last saw the deceased alive on August 13, 19 67 , and that death occurred at 9:15M , from causes and on the date stated above. | | | |
| 22a. SIGNATURE  | | 22b. DATE SIGNED August 13, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela Gomez, M.D. | | 22d. ADDRESS 7620 York Road, Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/16/67 | 23c. NAME OF CEMETERY OR CREMATORY Baltimore, Cemetery | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. |
| 24. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road. | | 25a. REC'D BY REGISTRAR AUG 16 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE  | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10592

CERTIFICATE OF DEATH

10592

| | | | |
|--|--------------------------------------|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN TB 530 Brook Road #4 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dulaney Valley Conv. Home | | d. STREET ADDRESS Towson Md. | |
| 3 NAME OF DECEASED (Type or print) Irene | | 4. DATE OF DEATH Month 8 Day 15 Year 1967 | |
| 5 SEX Female | 6. COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 5-22-1878 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | 9 AGE (in years last birthday) 89 yrs. |
| 11 BIRTHPLACE (County & State, or foreign country) Grand Rapids Mich. | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Frederick V. Lyon | | 14. MOTHER'S MAIDEN NAME Florence Mae Graham | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16 SOCIAL SECURITY NO. | |
| 17 INFORMANT Miss Helen French 530 Brook Road #4 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEVERE SECONDARY ANEMIA DUE TO (b) GASTRO-INTESTINAL HEMORRHAGE DUE TO (c) GASTRO-INTESTINAL MALIGNANCY | | INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS 1 YEAR 1 YEAR | |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) HYPERTENSIVE & CORONARY HEART DISEASE | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour "a.m." p.m. 19 | | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/5, 1962 to 8/15, 1967 , that (I) (we) last saw the deceased alive on 8/14, 1967 , and that death occurred at 6:20 AM , from causes and on the date stated above | | | |
| 22a SIGNATURE Donald L. Somerville | | 22b DATE SIGNED 8/15/67 | |
| 22c PHYSICIAN'S NAME (Type) DONALD L. SOMERVILLE, M.D. | | 22d ADDRESS 25 W. PA. AVE. TOWSON, MD 21204 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b DATE THEREOF 8-18-1967 | 23c NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery | 23d LOCATION (City or Town) (County) (State) Myak N.Y. |
| 24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road | | 25a RECD BY REGISTRAR 36 | |
| 25b REGISTRAR'S SIGNATURE J. Charles Jones | | DATE AUG 16 1967 | |

100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|------------------|--|---|--|---|--|---|--|----------------------------------|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 10593 Item #2 info, taken from birth cert. ph 20593 | | | | | | | | | | | |
| 1. PLACE OF DEATH | | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) | | | | | |
| a. COUNTY BALTIMORE | | | | | | a. STATE MD. b. COUNTY Baltimore | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | |
| BALTIMORE | | | | | | Towson 21204 | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | | d. STREET ADDRESS | | | | | |
| Greater Baltimore Medical Center | | | | | | 703 North Bend Road | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | | | | 4. DATE OF DEATH | | | | | |
| BABY GIRL FRIEDEL | | | | | | 8 Month 25 Day 19 67 | | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. IF UNDER 1 YEAR | |
| Female | | Cau | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8/25/67 | | 11 yrs. | | 11 Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country) | | | |
| --- | | | | --- | | | | --- | | | |
| 13. FATHER'S NAME | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Charles Thomas Friedel | | | | | | JOYCE Bay | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | Address | |
| (Yes, no, or unknown) | | | | --- | | Patient's Chart | | | | --- | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PRIMARY APNEA - | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ETIOLOGY UNDETERMINED. | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year | | | | 20d. INJURY OCCURRED | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) (State) | |
| Hour a.m. p.m. 19 | | | | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | |
| 21. I certify that (this hospital) attended the deceased from 8/25/67 to 8/25/67 , that (we) last saw the deceased alive on 8/25/67 and that death occurred at 9 P.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Neil H. Kowsky M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 8/27/67 | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) NEIL H. KOWSKY M.D. 22d. ADDRESS GREATER BALTIMORE MED CENTER | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town or county) (State) | | | |
| BURIAL | | | | 8/28/67 | | St Josephs | | Texas Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | | | | |
| John Burns Sons | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Towson | | | | | | AUG 29 1967 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10594

10594

| | | | | | | | |
|--|----------------------------------|---|---|--|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY County c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21222 (Dundalk) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | | | d. STREET ADDRESS 1957 Quentin Rd. | | | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Thomas Michael Frieze | | | | 4. DATE OF DEATH Month Day Year August 4, 1967 | | | |
| 5 SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH August 4, 1967 | 9. AGE (In years last birthday) yrs 6 | IF UNDER 1 YEAR Months Days 6 24 | IF UNDER 24 HRS Hours Min 6 24 | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10b KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (County & State, or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Harold Leslie Frieze | | | | 14. MOTHER'S MAIDEN NAME Billie Maxine Ellsleiger | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. NONE | | 17 INFORMANT Address Father, Mr. Harold L. Frieze, #2, a, b, c, d. | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Atelectasis DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) | | | |
| 21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/4/ , 19 67 , to 8/4/ , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/4/ , 19 67 , and that death occurred at 12:56 from causes on and on the date stated above. | | | | | | | |
| 22a SIGNATURE Jose A. Aguto | | M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b DATE SIGNED 8/4/67 | | | |
| 22c PHYSICIAN'S NAME (Type) Jose A. Aguto, M.D. | | 22d ADDRESS 7620 York Rd., Towson, Md. 21204 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF August-7-1967 | 23c NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus | | 23d LOCATION (City or Town) (County) (State) Dundalk, Maryland 21222 | | |
| 24 FUNERAL DIRECTOR JOHN J. DUDA, Dundalk, Maryland 21222 | | | 25a. REC'D BY REGISTRAR DATE AUG 9 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |



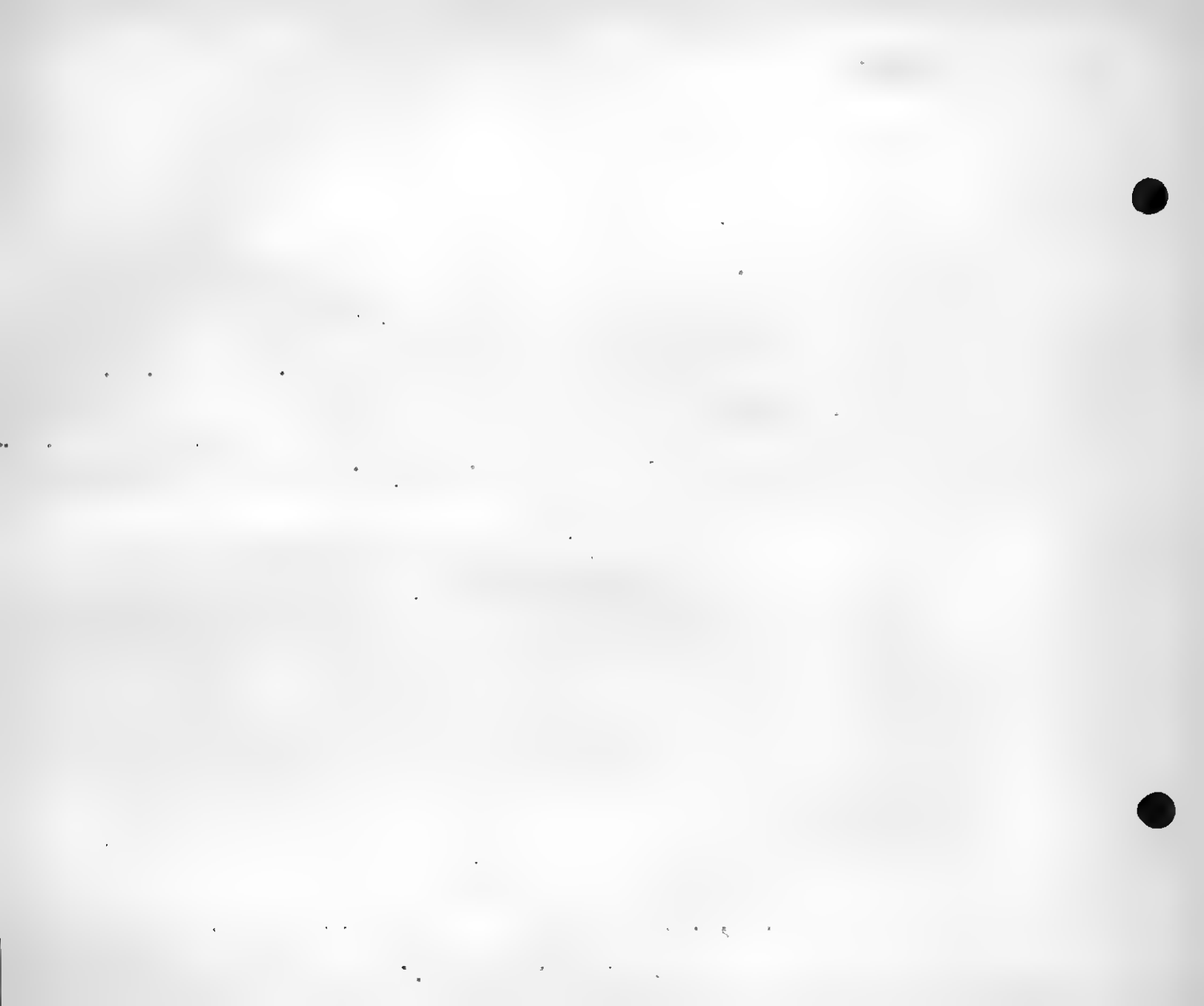
7 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10595 CERTIFICATE OF DEATH 10595

| | | | | | |
|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>17 Yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>705 Charing Cross Road</u> | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Zone 21229</u> 03-1 d. STREET ADDRESS <u>705 Charing Cross Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) <u>George F. Fromm</u> First Middle Last 4. DATE OF DEATH <u>August 1, 1967</u> Month Day Year | | | 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 22, 1910</u> 57 yrs. 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchaser</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Koppers Co.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u> | | | 13. FATHER'S NAME <u>George W. Fromm</u> 14. MOTHER'S MAIDEN NAME <u>Mary Stegman</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>214-05-3538</u> 17. INFORMANT <u>Mrs. Ruth C. Fromm</u> Address <u>Baltimore, Z.29.</u> | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Alkalosis</u> DUE TO (b) <u>Cerebral Pressure secondary to</u> DUE TO (c) <u>Brain Tumor</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June, 1967</u> to <u>1 Aug, 1967</u> , that (I) (we) last saw the deceased alive on <u>1 Aug, 1967</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <u>William J. Bryson</u> 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS | | | 22b. DATE SIGNED <u>3 Aug 67</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Aug. 4, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u> | |
| 23d. LOCATION (City, town or county) <u>Baltimore</u> | | 23e. (State) <u>Maryland</u> | | 24. FUNERAL DIRECTOR <u>Sterling Funeral Estate-736 Edmondson Ave. Catonsville, Md.</u> | |
| 25a. REC'D BY REGISTRAR <u>AUG 7 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u> | | | |



FOR STATE
HEALTH DEPT.

10596

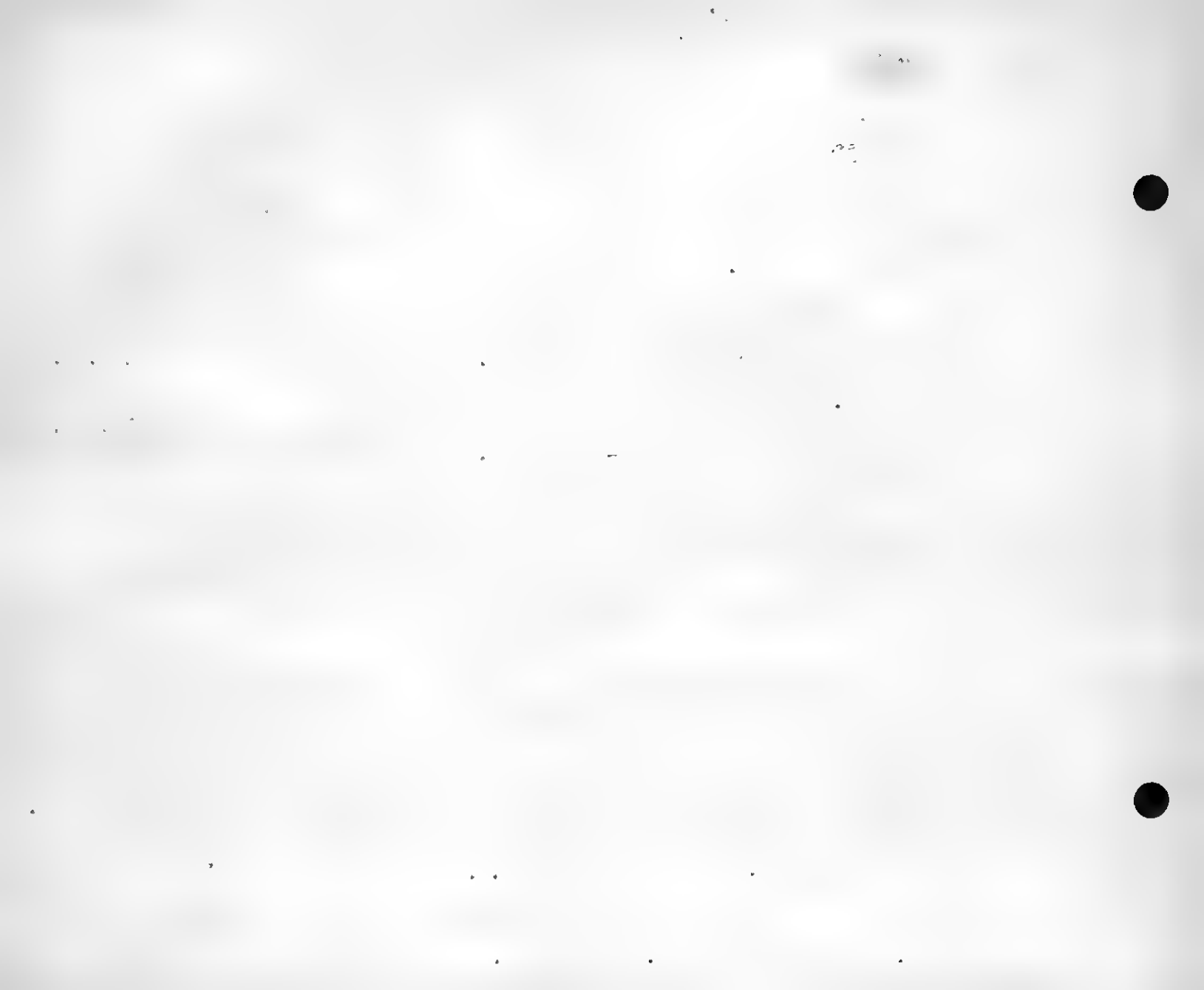
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10536

| | | | |
|---|---------------------------------|--|-------------------------------------|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk | | c. LENGTH OF STAY IN 1b 15 Months | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2910 Liberty Parkway | | d. STREET ADDRESS 2910 Liberty Parkway | |
| 3 NAME OF DECEASED (Type or print) First W. Middle Wingate Last Gallaway | | 4 DATE OF DEATH Month August Day 6 Year 19 67 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/16/98 |
| 9. AGE (In years last birthday) 68 yrs | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Open Hearth-- Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co. | |
| 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Richard J. Gallaway | | 14. MOTHER'S MAIDEN NAME Agnes Nutt | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO 213-09-4101 | |
| 17. INFORMANT (Wife) Mrs. Dorothy Gallaway, 2910 Liberty Parkway | | Address Dundalk, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4221 DUE TO A-S-C-V-Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Melvin B. Davis EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6800 Morningside Rd. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Dundalk, 8 / 6 / 67 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Md. 21222 Address (Street, city, town, or county) | |
| 23a. BURIAL CREMATION Burial (Specify) | | 23b. DATE THEREOF 8/9/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 23d. LOCATION (City or town) (County) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md. | | 25a. REC'D BY REGISTRAR DATE AUG 9 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10597

Items 3 & 4 filed 8/21/67 kk

10597

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown Balto.</u> | | c. LENGTH OF STAY IN It <u>Baltimore</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>7924 Dunhill Village Apt 201</u> | | d. STREET ADDRESS <u>7924 Dunhill Village Circle</u> | |
| 3. NAME OF DECEASED (Type or print) <u>SARAH FORMAN GERBER</u> | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>16</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Unknown</u> |
| 9. AGE (In years last birthday) <u>75</u> yrs | | 10. IF UNDER 1 YEAR Months <u></u> Days <u></u> | |
| 11. IF UNDER 24 HRS. Hours <u></u> Min <u></u> | | 12. COUNTRY OF WHAT COUNTRY? <u>USA</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (County & State or foreign country) <u>Russia</u> | | 12. COUNTRY OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Isaac Forman</u> | | 14. MOTHER'S MAIDEN NAME <u>Celia ?</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO <u></u> | |
| 17. INFORMANT <u>Samuel Gerber--7924 Dunhill Village Circle</u> | | Address <u></u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> 4300 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> , 19 <u>5/16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 1967</u> , and that death occurred at <u>12:41 A.M.</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Milton Kirsh</u> | | 22b. DATE SIGNED <u>8/16/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>MILTON KIRSH</u> | | 22d. ADDRESS <u>4000 W. Northern Parkway</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>8/16/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Chizuk Amuno</u> | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS INC. 6010 Reist Rd.</u> | | 25a. REC'D BY REGISTRAR DATE <u>AUG 18 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10598

CERTIFICATE OF DEATH

10588

| | | | |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Handwritten town</u> | | c. LENGTH OF STAY IN 1b <u>10 DAYS</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTO. Co. Gen. Hosp.</u> | | d. STREET ADDRESS <u>3605 A SYLVAN Dr.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>CAROLYN</u> Middle <u>MAE</u> Last <u>Gerold</u> | | 4. DATE OF DEATH Month <u>8</u> Day <u>7</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-10-94</u> |
| 9. AGE (In years last birthday) <u>73</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>G. Frederick Fuegel</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Annie Quitt Lobert</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WWII</u> | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMATION <u>GUSTAV A. Gerold</u> <u>Hosp. Record</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure, Chronic</u> DUE TO (b) <u>H.C.V.D.; Cardio Resp. Insuff.</u> DUE TO (c) <u>ATHEROSCLEROSIS, GENERALIZED</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>STROKE, Dehydration, FOCAL HEMORRHAGE</u> | | | |
| 19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>BRAIN STEM BASAL GANGLIA</u> | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from <u>7-28-1967</u> , to <u>8-2-1967</u> , that (I) (we) last saw the deceased alive on <u>8-7-1967</u> , and that death occurred at <u>3:45 AM</u> , from causes on and on the date stated above. | |
| 22a. SIGNATURE <u>Rolando A. Madamba, M.D.</u> | | 22b. DATE SIGNED <u>8-7-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>ROLANDO A. MADAMBA</u> | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>8-10-67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md</u> | |
| 24. FUNERAL DIRECTOR <u>Elkworth Armacost</u> | | 25a. REC'D BY REGISTRAR <u>4600 Liberty Hgts Ave</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | DATE <u>AUG 8 1967</u> | |



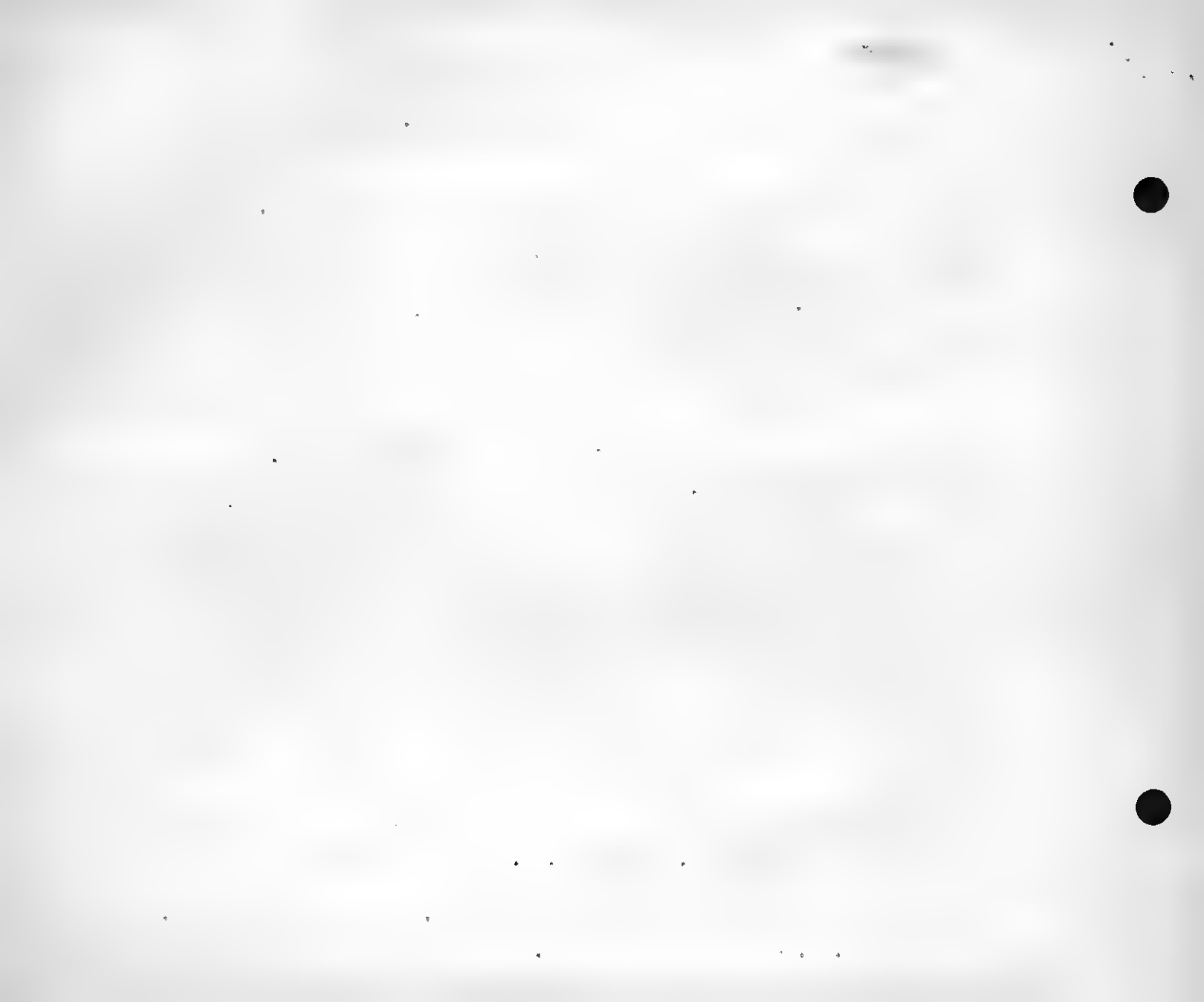
10599

CERTIFICATE OF DEATH

10599

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>_____</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Summitt Nursing Home</u> | | d. STREET ADDRESS <u>4902 Stafford St.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Leonard</u> Middle <u>Gilchrist</u> Last <u>_____</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>19 67</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>Cauc.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 20, 1895</u> |
| 9. AGE (In years last birthday) yrs <u>72</u> | | IF UNDER 1 YEAR Months <u>_____</u> Days <u>_____</u> Hours <u>_____</u> Min <u>_____</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work ng. life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Thomas Gilchrist</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Catherine Hayes</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>yes</u> <u>WW I</u> | |
| 16. SOCIAL SECURITY NO. <u>213-14-0730</u> | | 17. INFORMANT <u>Margaret Seymour</u> <u>4902 Stafford St.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY ARTERIOSCLEROSIS</u> DUE TO (b) <u>_____</u> DUE TO (c) <u>_____</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Esophageal Stenosis</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>_____</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>19 50</u> to <u>8/23, 19 67</u> that (I) (we) last saw the deceased alive on <u>8/22, 19 67</u> , and that death occurred at <u>1 1/2</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Thomas E. Roach</u> | | 22b. DATE SIGNED <u>8/23/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Thomas E. Roach, M. D.</u> | | 22d. ADDRESS <u>5550 Baltimore National Pike</u> | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>8/26/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u> | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u> |
| 24. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Ave.</u> | | 25a. REC'D BY REGISTRAR <u>AUG 29 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1-67

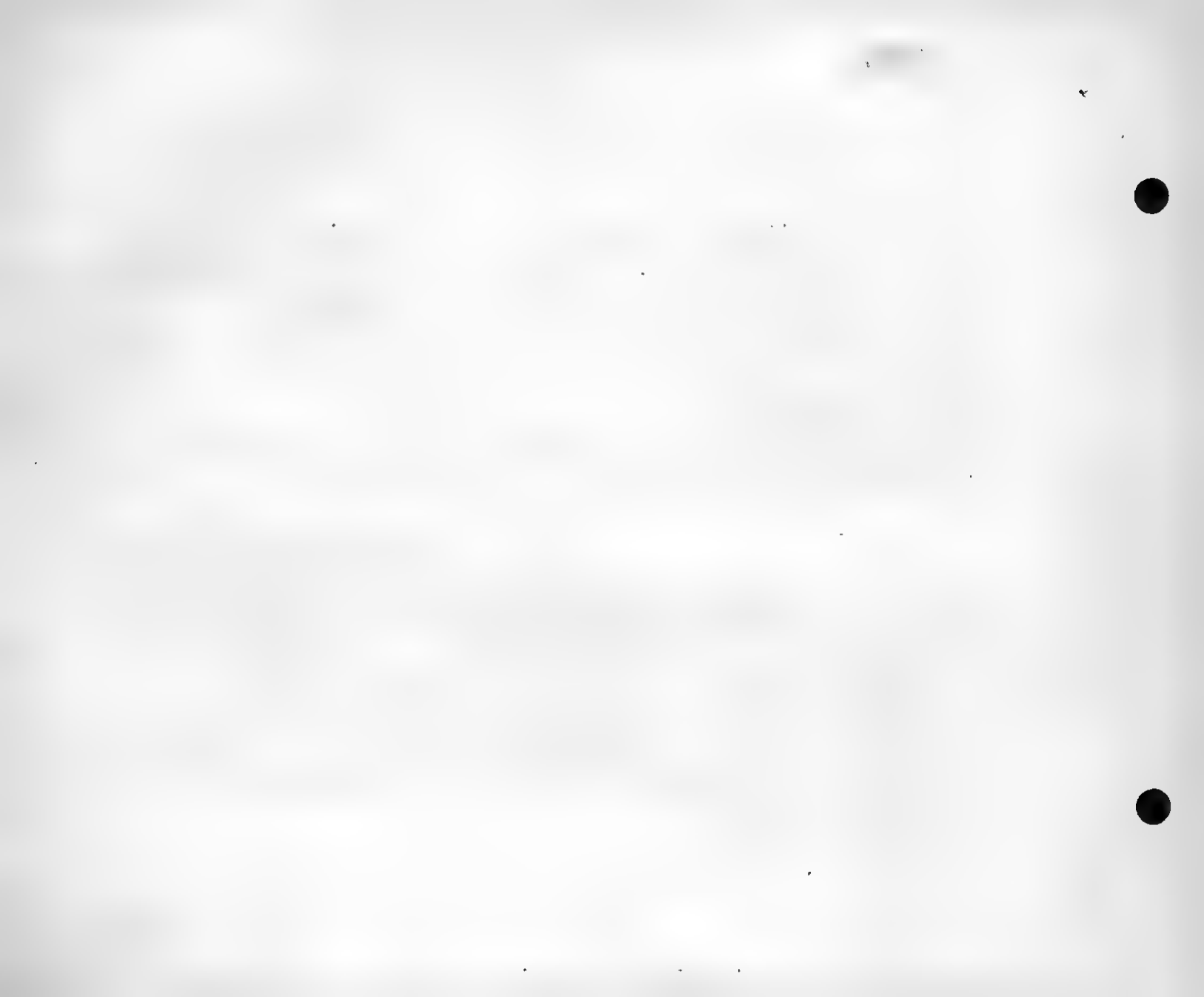
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10601

CERTIFICATE OF DEATH

10601

| | | | | | | | | | |
|--|--|---|-------------------------|--|--|--|---|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Woodholme Apts., Apt A</u> | | | | | | d. STREET ADDRESS <u>Woodholme Apts., Apt A</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First <u>Meyer</u> Middle <u>B.</u> Last <u>Goldstein</u> | | | | 4 DATE OF DEATH Month <u>14</u> Day <u></u> Year <u>19 67</u> <u>August 14, 1967</u> | | | | | |
| 5 SEX <u>Male</u> | | 6 COLOR OR RACE <u>White</u> | | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH <u>Feb. 27, 1902</u> | | 9 AGE (in years last birthday) <u>65</u> yrs | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale</u> | | 11 BIRTHPLACE (County & State or foreign country) <u>New York, New York</u> | | | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>Barnet Goldstein</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16 SOCIAL SECURITY NO <u>216-03-0139</u> | | 17 INFORMANT Address <u>Apt A</u> <u>Mrs. Lillian Goldstein, 8001 Woodgate Ct.</u> | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary thromboses</u> 7201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>A.S.H.P.</u> DUE TO (c) <u></u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6/11, 1960</u> to <u>present</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/13</u> 19 <u>67</u> , and that death occurred at <u>12:30 AM</u> , from causes on and the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>Bernard Burgin</u> | | | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED <u>8/14/67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. Bernard Burgin</u> | | | | 22d. ADDRESS <u>6721 Reisterstown Road</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>8/15/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cholatz Chaim</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>AUG 17 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10600

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10600

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY 17 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 6649 Wycombe Way e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) MORRIS GOLDSTEIN SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH June 15, 1901 9. AGE (In years lost birthday) 66 yrs FUNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min | | 4. DATE OF DEATH August 4, 19 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman 10b. KIND OF BUSINESS OR INDUSTRY Salesman 11. BIRTHPLACE (State or foreign country) New York 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Solomon 14. MOTHER'S MAIDEN NAME Leiter | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO Bartram Goldstein 17. INFORMANT 4504 Seetha Level Ct | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Myocardial Infarct 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Abrasions and Contusions of back 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Subj. involved in mild automobile accident 20c. TIME OF INJURY Month, Day, Year Hour a.m. Unk p.m. 8/2 19 67 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Street 20f. (City or town) (County) (State) Baltimore, Md. | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 8/5/67 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 8/6/67 23c. NAME OF CEMETERY OR CREMATORY Beth El 23d. LOCATION (City or town) (County) (State) Randallstown Md | | 24. FUNERAL DIRECTOR Sylvan S. Lewis & Son, Inc. Garrison Rd ADDRESS 25a. REC'D BY REGISTRAR DATE AUG 8 1967 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|--|--|------------------|---|---|--|---|--|---|------------------------------|--|---------|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | |
| 10602 | | | | | 10602 | | | | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | | | |
| a. COUNTY Baltimore | | | | | a. STATE Maryland b. COUNTY Baltimore | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | | | | | | |
| Ruxton | | | | | Ruxton | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | d. STREET ADDRESS | | | | | | | |
| 1019 Wagner Road | | | | | 1019 Wagner Road | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | | | 4. DATE OF DEATH | | | | | | | |
| First Middle Last | | | | | Month Day Year | | | | | | | |
| MARY ELIZABETH GOODALL | | | | | August 16 19 67 | | | | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (in years last birthday) | | | | |
| Female | | Cau. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | April 10, 1915 | | 52 yrs. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (County & State, or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Housewife | | | Home | | | Pennsylvania | | | U. S. A. | | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | |
| Granville B. Hopkins | | | | | Helan Hancock | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT | | | Address | | |
| | | | | | | | Mr. Robert D. Goodall, Same as # 2 | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac Failure, pulmonary oedema | | | | | | | | | | 12-24 hrs. | | |
| DUE TO (b) Anemia, oachexia | | | | | | | | | | 21 months | | |
| DUE TO (c) Hypernephroma with multiple metastases | | | | | | | | | | 21 months | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year | | | 20d. INJURY OCCURRED | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| Hour a.m. p.m. | | | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | | | |
| 21. I certify that (I) (the hospital) attended the deceased from 9/29/49 , 19 49 , to 8/15 , 19 67 , that (I) (we) last saw the deceased alive on 8/15 , 19 67 , and that death occurred at 1:30 A.M. from the causes and on the date stated above. | | | | | | | | | | | | |
| 22a. SIGNATURE | | | | | | | | | | 22b. DATE SIGNED | | |
|  | | | | | | | | | | 8/16/67 | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | 22d. ADDRESS | | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | |
| Benjamin H. Rutledge, M.D. | | | | | 16 E. Eager Street, Baltimore, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City, town or county) (State) | | | | |
| BURIAL | | | Aug. 18, 1967 | | Church of Messiah Cemetery | | | Gwynedd, Pennsylvania | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204 | | | | | | AUG 18 1967 | |  | | | | |



10603

CERTIFICATE OF DEATH

20603

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

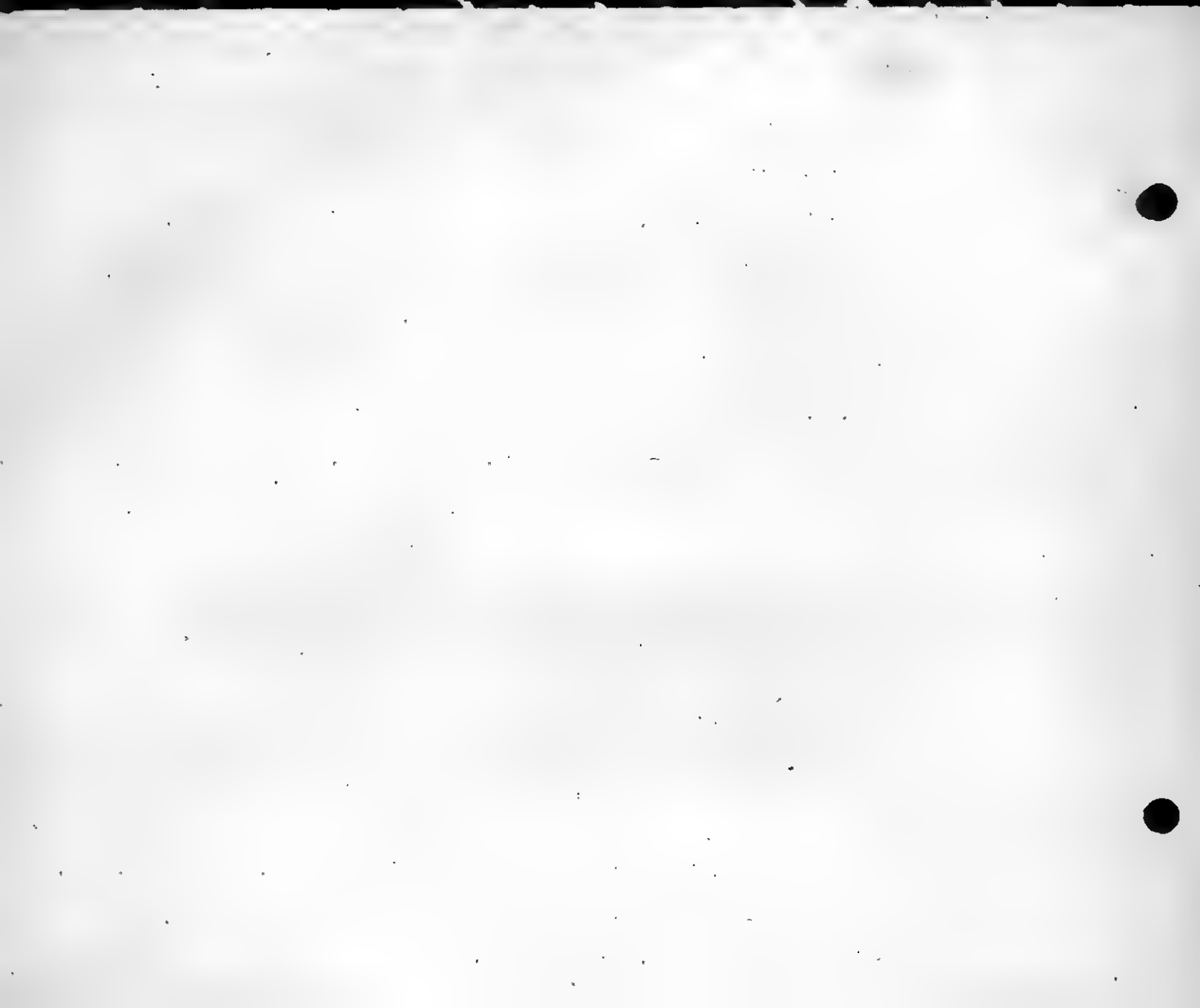
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|---|---|---|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | c. LENGTH OF STAY IN TB <u>Life</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center.</u> | | d. STREET ADDRESS <u>311 Willow Ave 36</u> | |
| 3 NAME OF DECEASED (Type or print) <u>Casper</u> First Middle Last <u>John Gossman</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>1967</u> | |
| 5 SEX <u>Male</u> | 6 COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>8-13-93</u> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 9. AGE (In years lost birthday) <u>73</u> yrs | |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>National Casket</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u> | |
| 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13 FATHER'S NAME <u>John</u> | |
| 14 MOTHER'S MAIDEN NAME <u>Not Known</u> | | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | |
| 16 SOCIAL SECURITY NO. <u>213-05-4511</u> | | 17. INFORMANT <u>Admission sheet</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO (b) <u>Ca of buccal mucosa with metastases to diff. floors, diabetes mellitus</u> DUE TO (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/17</u> , 19 <u>67</u> , to <u>8/7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/7</u> , 19 <u>67</u> , and that death occurred at <u>7:50 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>J. Galloway</u> | | 22b. DATE SIGNED <u>8/7/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr Galloway</u> | | 22d. ADDRESS <u>36</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>8-10-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u> | 23d. LOCATION (City or town) (County) (State) <u>Baltimore, City Md.</u> |
| 24. FUNERAL DIRECTOR <u>Lasson Funeral Home 2401 Belair Road</u> | | 25a REC'D BY REGISTRAR DATE <u>AUG 9 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10604 CERTIFICATE OF DEATH 20604

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills | | c. LENGTH OF STAY IN ID 2 years | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Baptist Home of Md. | | d. STREET ADDRESS 244 Rodgers Forge Rd. | |
| 3. NAME OF DECEASED (Type or print) BESSIE RYAN GOULD | | 4. DATE OF DEATH Month August Day 23 Year 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 21, 1870 |
| 9. AGE (In years last birthday) 97 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Robert S. Ryan | | 14. MOTHER'S MAIDEN NAME Annie Boswell | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 218-54-3476 | |
| 17. INFORMANT Mrs. Elizabeth G. Reitz | | Address 244 Rodgers Forge Rd | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) Carcinoma of left Breast with metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arterio Sclerosis | | | INTERVAL BETWEEN ONSET AND DEATH 1 year |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) none | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (the hospital) attended the deceased from June , 1966 to Aug. 23, 1967 , that (we) last saw the deceased alive on Aug. 19 , 1967, and that death occurred at 10:45 M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Earl L. Chambers | | 22b. DATE SIGNED 8/25/67 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Earl L. Chambers | | 22d. ADDRESS 4108 Liberty Hgts. Ave. Balto., Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8-25-67 | 23c. NAME OF CEMETERY OR CREMATORY Green Mount | 23d. LOCATION (City, town or county) (State) Baltimore, Maryland |
| 24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212 | | 25a. REC'D BY REGISTRAR AUG 28 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

10605
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
Item # 8 FilmG392 8/24/67
CERTIFICATE OF DEATH
10605

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chase</u> c. LENGTH OF STAY IN It <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ivy Hall Nursing Home</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chase</u> d. STREET ADDRESS <u>Box 93 Chase, Maryland 21027</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>V.</u> Last <u>GRAY</u> | | 4. DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4/23/1898</u> AGE (In years last birthday) <u>69 yrs</u> IF UNDER 1 YEAR Months <u>6</u> Days <u>18</u> IF UNDER 24 HRS Hours <u>18</u> Min. <u>45</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u> | 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> |
| 13. FATHER'S NAME <u>Michael Daughtery</u> | | 14. MOTHER'S MAIDEN NAME <u>Julia Martin</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>534X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Vascular disease</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____ | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8/17</u> , 19 <u>67</u> to <u>8/17</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8/17</u> , 19 <u>67</u> , and that death occurred at <u>3:00</u> A.M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Samuel Stern</u> M.D. | | 22b. DATE SIGNED <u>8/21/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>SAMUEL STERN</u> | | 22d. ADDRESS <u>(36)</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>8-21-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u> | 23d. LOCATION (City, town or county) <u>Baltimore</u> (State) <u>Co. Md.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>AUG 21 1967</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10606

CERTIFICATE OF DEATH

10606

| | | | |
|---|--|---|--|
| 1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN 1b 120 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | e. STREET ADDRESS 4339 Reisterstown Rd. | |
| 3. NAME OF DECEASED (Type or print) First Middle Last THOMAS S. GREEN | | 4 DATE OF DEATH Month Day Year AUGUST 2 19 67 | |
| 5 SEX MALE | 6 COLOR OR RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 9/13/21 |
| 9 AGE (n years lost birthday) 45 yrs | | 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER | |
| 10b KIND OF BUSINESS OR INDUSTRY - | | 11 BIRTHPLACE (County & State, or foreign country) WILMINGTON, N. C. | |
| 12 CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME JAMES GREEN | |
| 14. MOTHER'S MAIDEN NAME MARY REGISTER | | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES ARMY | |
| 16 SOCIAL SECURITY NO 213 18 39 91 | | 17 INFORMANT Address CLINICAL RECORDS VA HOSPITAL FORT HOWARD, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LARYNX AND EPIGLOTTIS DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) | | | INTERVAL BETWEEN ONSET AND DEATH 6 Months |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from APRIL 4 , 19 67 , to AUGUST 2, 1967 , that (I) (we) last saw the deceased alive on AUGUST 2 19 67 , and that death occurred at 12:15 PM on the date stated above. | | | |
| 22a. SIGNATURE <i>Ahmed Kutty</i> | | 22b. DATE SIGNED 8/2/67 | |
| 22c. PHYSICIAN'S NAME (Type) AHMED KUTTY, M.D. | | 22d. ADDRESS VAH FORT HOWARD, MARYLAND | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b DATE THEREOF 8/15/67 | 23c NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PARK | 23d LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND |
| 24 FUNERAL DIRECTOR ARLINGTON S. PHILLIPS 1727 N. MONROE ST. BALTO | | 25a REC'D BY REGISTRAR AUG 7 1967 | 25b REGISTRAR'S SIGNATURE <i>Charles Judge</i> |



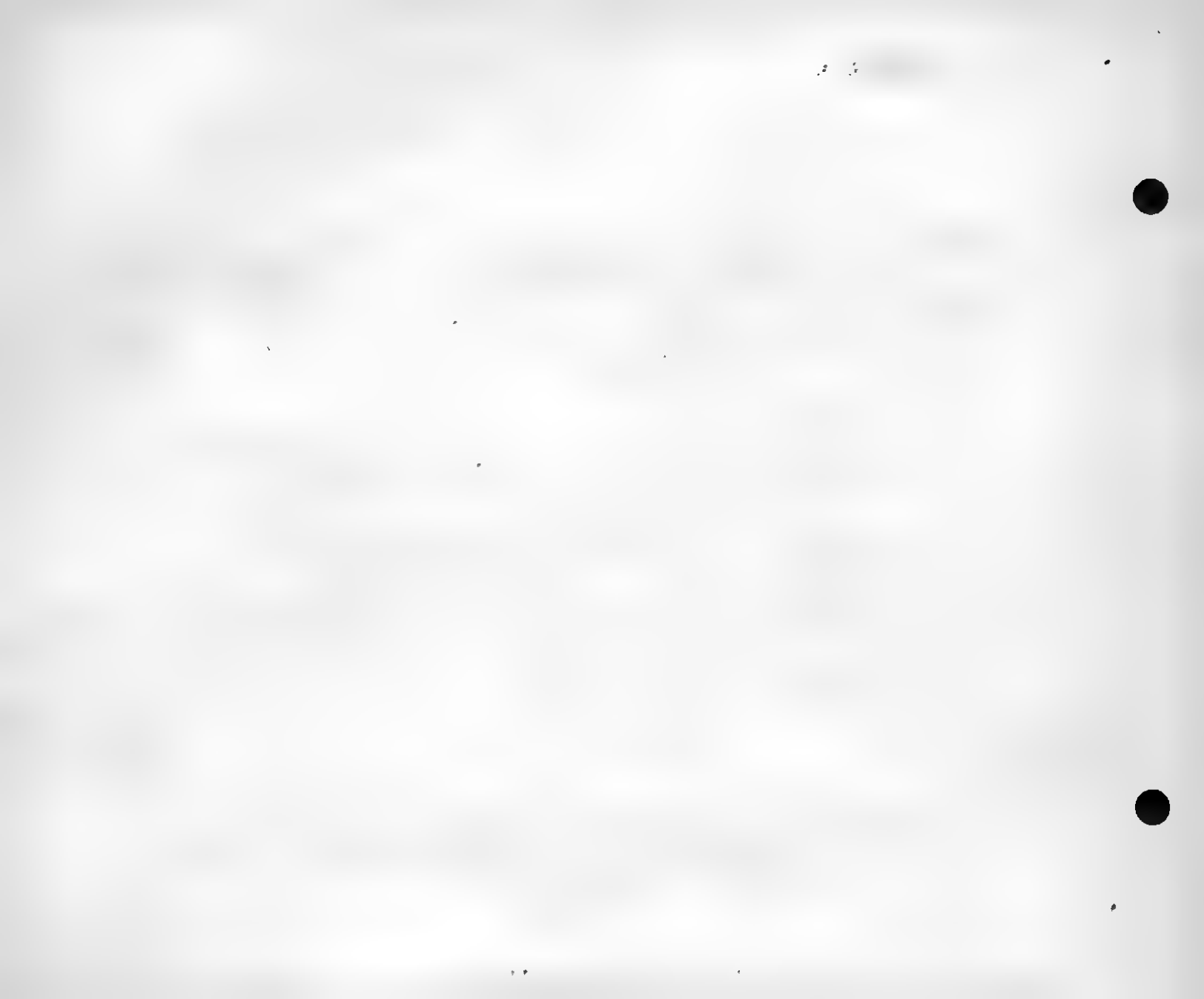
10607

CERTIFICATE OF DEATH

10607

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3602 Clifmar Road</u> | | d. STREET ADDRESS <u>3602 Clifmar Road</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Gertrude Gladys Greenfield</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 12, 1904</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> | |
| 13. FATHER'S NAME <u>David Greenfield</u> | | 14. MOTHER'S MAIDEN NAME <u>Rebecca Dembo</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) <u>No</u> | | 17. INFORMANT <u>Mrs. Dorothea Vospy, 3602 Clifmar Road #7</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>157X</u> DUE TO <u>breast cancer</u> (b) <u>metastatic cancer</u> DUE TO <u>breast cancer</u> (c) <u>breast cancer</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>11 mo</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 20, 1946</u> to <u>Aug 31, 1967</u> that (I) (we) last saw the deceased alive on <u>Aug 31, 1967</u> and that death occurred at <u>10:15 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Dr. Lester Kolman</u> M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. Lester Kolman</u> | | 22d. ADDRESS <u>3700 Park Heights Avenue</u> | |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>9/3/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Ohel Yabov</u> | 23d. LOCATION (City or town) (County) (State) <u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u> | | 25a. REC'D BY REGISTRAR <u>SEP 6 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10608

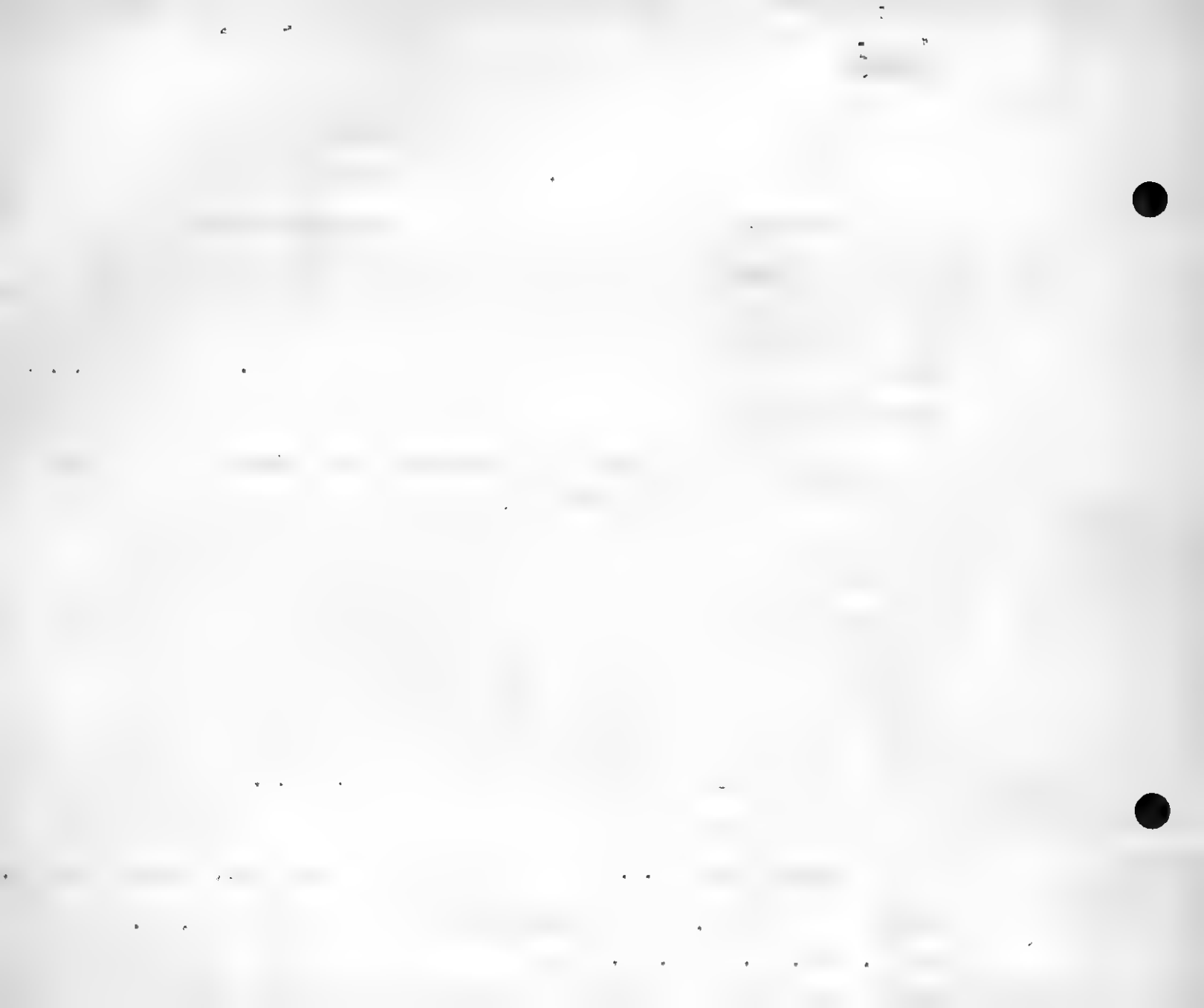
10608

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills | | c. LENGTH OF STAY IN 1b 7 yrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital | | d. STREET ADDRESS 4555 Shamrock Avenue | |
| 3 NAME OF DECEASED (Type or print) First Donald Middle Gerald Last GRIFFITHS | | 4. DATE OF DEATH Month 8 Day 31 Year 19 67 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-9-58 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent | | 10b. KIND OF BUSINESS OR INDUSTRY none | 9. AGE (In years last birthday) 9 yrs |
| 11. BIRTHPLACE (County & State, or foreign country) Baltimore City, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Stephen Griffiths | | 14. MOTHER'S MAIDEN NAME Audrey Helene McGee | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Rosewood Records, Owings Mills, Maryland | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atrial Fibrillation 4001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 9-25 , 19 59 , to 8-31 , 19 67 , that (I) (we) last saw the deceased alive on 8-31 , 19 67 , and that death occurred at 9:45 Marion causes and on the date stated above. | | | |
| 22a. SIGNATURE Angelio Garcia | | 22b. DATE SIGNED 8-31-67 | |
| 22c. PHYSICIAN'S NAME (Type) Angelio Garcia, M.D. | | 22d. ADDRESS Rosewood State Hosp., Owings Mills, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 9/2/67. | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | 25a. REC'D BY REGISTRAR SEP 5 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10603

10609

| | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|--|--|---------------------------|--|---|--|--------------------------------------|--|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Foxleigh</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>BALTO</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>700 N. Lakewood Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Nellie</u> First <u>T</u> Middle <u>Hale</u> Last | | 4. DATE OF DEATH Month <u>8</u> Day <u>12</u> Year <u>1967</u> | | 5. SEX <u>F.</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>6-20-1886</u> | | 9. AGE (In years last birthday) <u>81</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>8</u> Days <u>12</u> Hours <u>19</u> Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | | | | 11. BIRTHPLACE (County & State, or foreign country) <u>Cambridge, Md.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Delma Stinchcombe</u> | | | | | | | | 14. MOTHER'S MAIDEN NAME <u>Frances Steward</u> | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>217-48-4599</u> | | | | 17. INFORMANT <u>Gladys Grove, sister, 6709 Mt. Vernon Ave.</u> Address <u>#15</u> | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO (b) <u>Adenocarcinoma of the ovary</u> DUE TO (c) <u>unknown</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (1) (this hospital) attended the deceased from <u>8-2</u> , 19 <u>67</u> , to <u>8-12</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>8-10</u> , 19 <u>67</u> , and that death occurred at <u>12:45</u> M, from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>David I. Miller</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | 22b. DATE SIGNED <u>8-12-67</u> | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>David I. Miller</u> | | | | | | | | | | | | 22d. ADDRESS <u>Leuson Rd. - Owings Mills, Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>8/14/67</u> | | | | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u> | | | | 23d. LOCATION (City, town or county) (State) <u>Balto., Md.</u> | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Schimunek Funeral Home</u> ADDRESS <u>2601-03-05 E. Madison Street #5</u> | | | | | | | | | | | | 25a. REC'D BY REGISTRAR <u>AUG 15 1967</u> | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|---|--|-------------------------------|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY in 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Baptist Home of Md. | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4407 Falls Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) EMMA E. HALL First Middle Last | | | | | 4. DATE OF DEATH August 4, 1967 Month Day Year | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Nov. 23, 1872 | | 9. AGE (In years last birthday) 94 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (County & State, or foreign country) Somerset Co., Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Aurelius Long | | | | | 14. MOTHER'S MAIDEN NAME Ruff | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Baptist Home of Md. Owings Mills, Md. Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis DUE TO (b) Renal Vascular disease DUE TO (c) Permissive Anemia. Conf. Face CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Serility | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 1967 to Aug 4, 1967 , that (I) (we) last saw the deceased alive on Aug 4, 1967 , and that death occurred at 384 M , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Dr. M. Paul Byerly | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 5/4/67 | | |
| 22c. PHYSICIAN'S NAME (Type) Dr. M. Paul Byerly | | | | | 22d. ADDRESS 5820 York Rd. Baltimore, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF 8-7-67 | | 23c. NAME OF CEMETERY OR CREMATORY Grace Methodist Church | | 23d. LOCATION (City, town or county) (State) Falls Rd Balto. Co. Md | | |
| 24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. ADDRESS 6500 York Rd. Baltimore Md. 21212 | | | | | 25a. REC'D BY REGISTRAR AUG 7 1967 25b. REGISTRAR'S SIGNATURE Charles J. Jones | | | | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

10611

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10611

| | | | |
|---|---------------------------------|---|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b 3 Yrs | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore 21204 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1414 Putty Hill Road | | d. STREET ADDRESS 1414 Putty Hill Road * IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) George Aloysius Hall | | 4 DATE OF DEATH 8-5-67 Month 8 Day 5 Year 19 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH July 17 1890 9 AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | |
| 11 BIRTHPLACE (State or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George George Hall | | 14 MOTHER'S MAIDEN NAME Mary Casby | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) (If yes give war or dates of service) No | | 16 SOCIAL SECURITY NO. 717 07 7414 | |
| 17 INFORMANT Geo. R. Hall 967 Spruce St. Pottstown Pa. | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per one for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Generalized Arteriosclerosis DUE TO (c) 57 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | INTERVAL BETWEEN ONSET AND DEATH Sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles F. O'Donnell M.D. | | 22. DATE SIGNED 8/5/67 | |
| EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | 23b. DATE THEREOF 8-8-67 | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland. |
| 24 FUNERAL DIRECTOR Wm. E. Johnson, 8521 Loch Raven Blvd., 21204 Balto. Md. | | 25a. REC'D BY REGISTRAR AUG 8 1967 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

10612

10612

CERTIFICATE OF DEATH

| | | | |
|---|----------------------------------|---|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c LENGTH OF STAY IN 1b 11mth16dys | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | e STREET ADDRESS 2000 Tuckerman Street | |
| 3 NAME OF DECEASED (Type or print) James Nelson Hall | | 4. DATE OF DEATH Month August Day 17 Year 1967 | |
| 5 SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH June 29, 1893 |
| 9 AGE (in years last birthday) 74 yrs | | 10a. SOCIAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist | |
| 10b. KIND OF BUSINESS OR INDUSTRY Instrument Maker | | 11 BIRTHPLACE (County & State, or foreign country) Connecticut | |
| 12 CITIZEN OF WHAT COUNTRY? U. S. | | 13. FATHER'S NAME George Hall | |
| 14. MOTHER'S MAIDEN NAME Mary Kelly | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes U.S. Army | |
| 16 SOCIAL SECURITY NO 213-24-3853 | | 17 INFORMANT EMMA HALL Address # 2 Records: SPRING GROVE STATE HOSPITAL | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. 223X IMMEDIATE CAUSE (a) Subarachnoid hemorrhage DUE TO (b) Porencephalic cyst, left occipital lobe DUE TO (c) 3 years | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral hemorrhage 1965 and 4-1966 treated at V.A.H. - Wash., D.C. | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from Sept. 1, 1966 to Aug. 17, 1967 that (X) (we) lost saw the deceased alive on Aug. 17, 1967 , and that death occurred at 4:40 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Anthony J. Young, M.D. | | 22b. DATE SIGNED 8-17-67 | |
| 22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D. | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF August 21, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md. | |
| 24. FUNERAL DIRECTOR C. Glen Carter | | 25a. REC'D BY REGISTRAR Warner E. Pumphrey Funeral Home Silver Spring | |
| 25b. REGISTRAR'S SIGNATURE Charles J. Jones | | 25c. DATE AUG 28 1967 | |

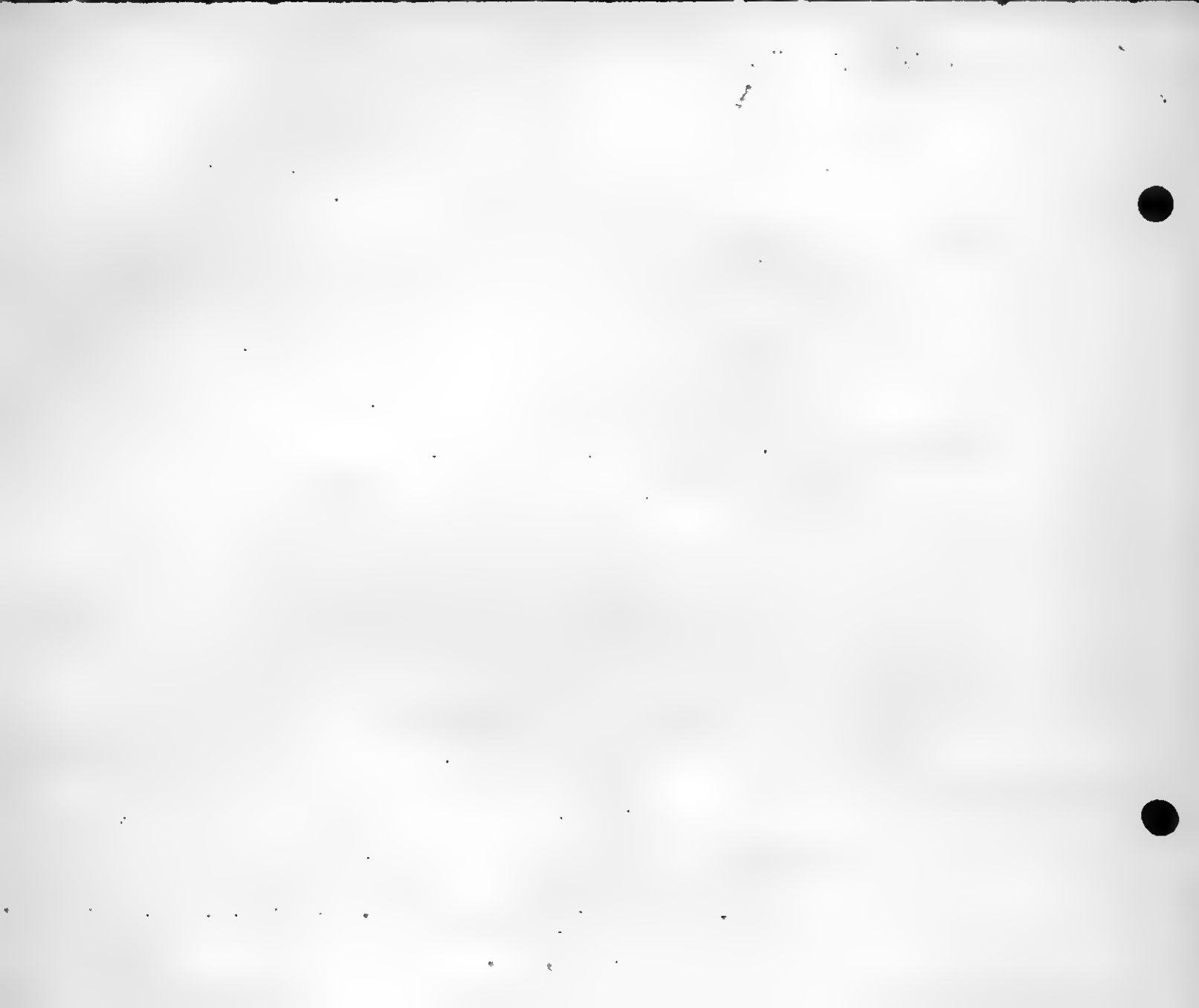
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 74
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | |
|--|---|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY IN 1b 18 hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER RD 1 BOX 229 | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HAYRE de GRACE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAYRE de GRACE d. STREET ADDRESS BOX 229 | | 6. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last GLENN B HAMILTON | | 4. DATE OF DEATH Month Day Year 8 27 19 67 | | | |
| 5. SEX MALE | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-3-27 | 9. AGE (In years last birthday) 40 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SERVICE STATION OPERATOR | | 10b. KIND OF BUSINESS OR INDUSTRY SERVICE STATION | | 11. BIRTHPLACE (County & State, or foreign country) HAYRE de GRACE | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME CHARLES H. HAMILTON | | 14. MOTHER'S MAIDEN NAME OZELLA PHILLIPS | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) XXXXXX Korean | | 16. SOCIAL SECURITY NO. 220 20 7434 | | 17. INFORMANT PATIENT'S CHART | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis of lungs 1992 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) oral carcinoma IMMEDIATE CAUSE (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 8/26/67 , 19 67 , to 8/27 , 19 67 , that (I) (we) last saw the deceased alive on 8/27 , 19 67 , and that death occurred at 2:15M , from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Eduardo M. Canilang | | ATTENDING PHYS. <input type="checkbox"/> M.O. <input type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) EDUARDO M. CANILANG | | 22d. ADDRESS GREATER BALTO. MED. CENTER | | 22b. DATE SIGNED 8/27/67 | |
| 23a. BURIAL CREMATION REMOVAL (Specify) Burial | 23b. DATE THEREOF 30 Aug. 67 | 23c. NAME OF CEMETERY OR CREMATORY Wesleyan Chapel Cem. | 23d. LOCATION (City, town or county) (State) Aberdeen, (Harford) Md. | | |
| 24. FUNERAL DIRECTOR Tarring Funeral Home | | 25a. REC'D BY REGISTRAR AUG 29 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

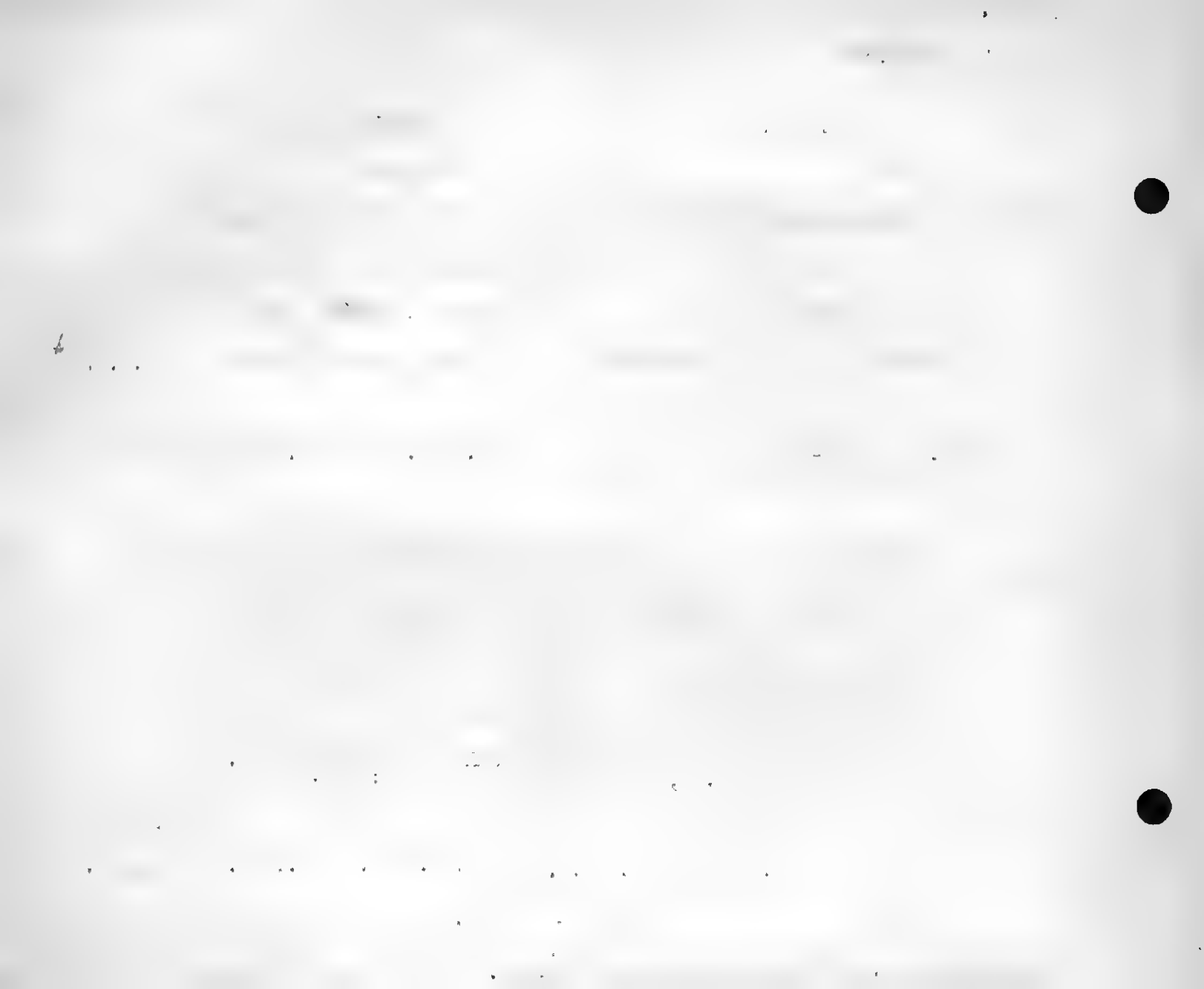
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10614

CERTIFICATE OF DEATH

10614

| | | | | | |
|--|---|---|--|----------|--|
| 1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY --- | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN TB 23 DAYS | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMINISTRATION HOSPITAL | | | d. STREET ADDRESS 1359 WEST NORTH AVENUE | | e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3 NAME OF DECEASED (Type or print) First LEWIS Middle ADAM Last HANLEY | | | 4 DATE OF DEATH Month AUGUST Day 6 Year 19 67 | | |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MARCH 7, 1893 | | 9. AGE (In years .ay) last yrs 74 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY RAILROAD | 11. BIRTHPLACE (County & State or foreign country) WYTHE COUNTY, VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW-1 | | 16. SOCIAL SECURITY NO 719 14 03 06 | 17. INFORMANT CLIN. REC., VAH, FT. HOWARD, MARYLAND | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO (b) CARCINOMA OF PROSTATE DUE TO (c) --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 14 , 19 67 , to Aug. 6 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Aug. 6 , 19 67 , and that death occurred 8:00 A.M. from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <i>John C. Dumlley, Jr.</i> | | | 22b. DATE SIGNED 8/6/67 | | |
| 22c. PHYSICIAN'S NAME (Type) JOHN C. DUMLEY, JR., M.D. | | | 22d. ADDRESS VET. ADM. HOSP., FT. HOWARD, MD. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8-9-67 | 23c. NAME OF CEMETERY OR CREMATORY Balto. Nat'l. Cem. | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | | |
| 24. FUNERAL DIRECTOR GEORGE J. KELSON FUNERAL HOME | | 25a. REC'D BY REGISTRAR 1346 N. Calhoun St. Balto. Md. | 25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i> | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed, within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|---|--|---|---|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Timonium</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Timonium</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>207 . Timonium road</u> | | | | | d. STREET ADDRESS <u>207 . Timonium road</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Mark</u> Middle <u>Patrick</u> Last <u>Hanley</u> | | | | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>18</u> Year <u>1967</u> | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>ec. 5, 1905</u> | | 9. AGE (in years last birthday) <u>61</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Patrick Hanley</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Rose Smith</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | | 16. SOCIAL SECURITY NO. <u>214-30-4579</u> | | 17. INFORMANT <u>Family records</u> Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>190.9</u> DUE TO (b) <u>Malignant Melanoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>3 yrs.</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1945</u> to <u>Aug 18, 1967</u> that (I) <u>last</u> saw the deceased alive on <u>15 August 1967</u> and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>Charles W. Council</u> M.D. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | 22d. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Aug. 22, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mount Maria Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Towson, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u> | | | | | 25a. REC'D BY REGISTRAR DATE <u>AUG 24 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

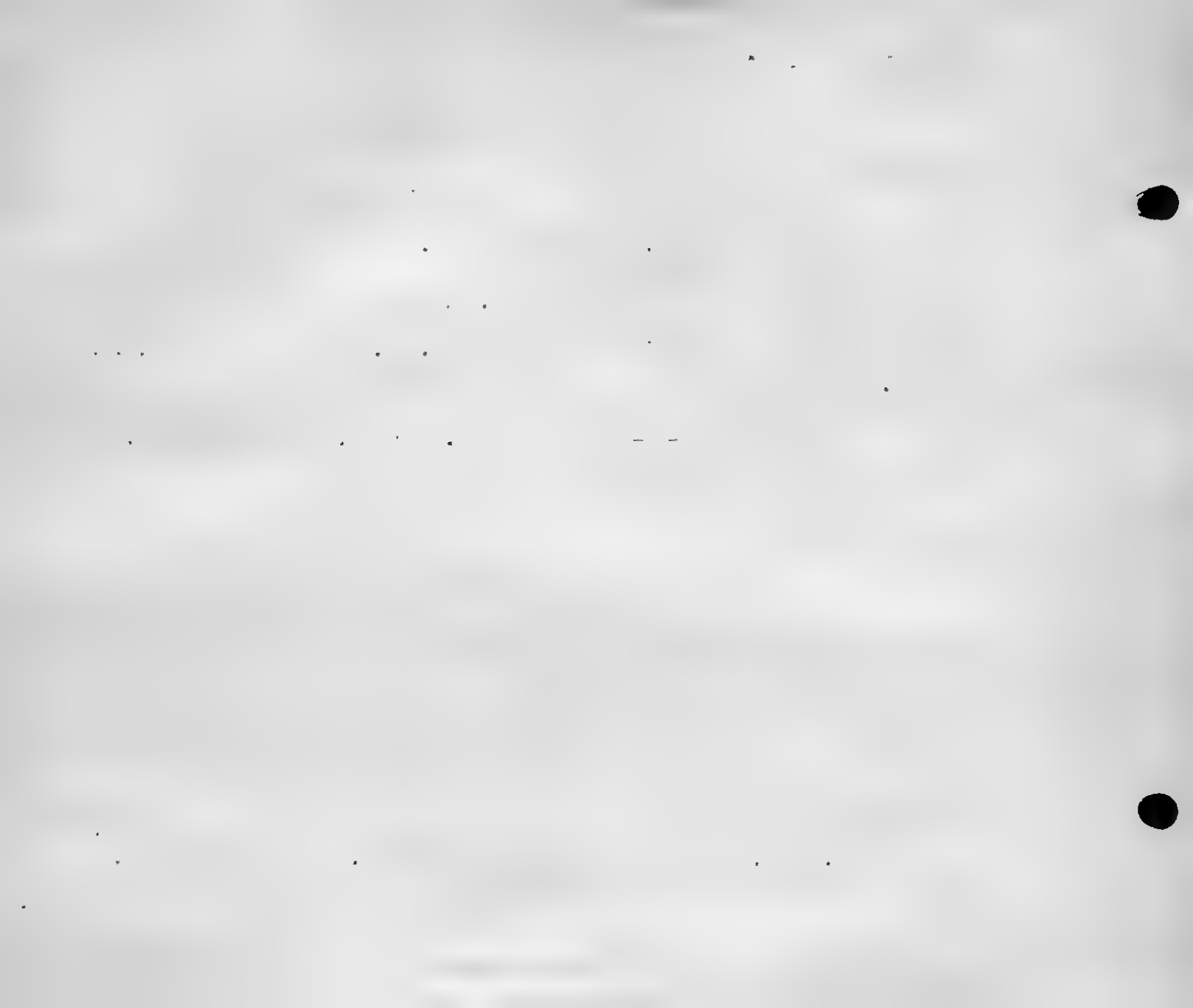
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all tags, papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10616

10616

| | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|--------------------------------------|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Randallstown c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Chapel Hill Nursing Home | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn d. STREET ADDRESS 6412 Windsor Mill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Howard First Middle Last R. Harr, Sr. | | 4. DATE OF DEATH August 17 1967 Month Day Year | | 5. SEX Male | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Jan. 3, 1882 | | 9. AGE (In years last birthday) 85 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Examiner | | | | 10b. KIND OF BUSINESS OR INDUSTRY Banking | | | | 11. BIRTHPLACE (County & State, or foreign country) Balto. Md. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Jacob A. Harr | | | | 14. MOTHER'S MAIDEN NAME Arabella Waterhouse | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war and dates of service) | | | | 16. SOCIAL SECURITY NO. 212-09-3792 | | 17. INFORMANT Howard R. Harr Jr. 8905 Flagstone Circle Randallstown, Md. 21133 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last (c) } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 1967 to 8/17/1967 , that (I) (we) last saw the deceased alive on 8/17/1967 , and that death occurred 7:28 M, from the causes and on the date stated above. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE Wm E. Martin 22c. PHYSICIAN'S NAME (Type) Dr. Wm E. Martin | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 8/18/67 | | | | | | | |
| 23a. BURIAL, CREMATION, (Specify) BURIAL | | | | 23b. DATE THEREOF 8/21/67 | | 23c. NAME OF CEMETERY OR CREMATORY St Paul's Lutheran Church | | 23d. LOCATION (City, town or county) (State) Uniontown Carroll Co Md. | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers ADDRESS 8728 Liberty Rd. Randallstown | | | | | | 25a. REC'D BY REGISTRAR Charles Judge | | 25b. REGISTRAR'S SIGNATURE | | DATE AUG 21 1967 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

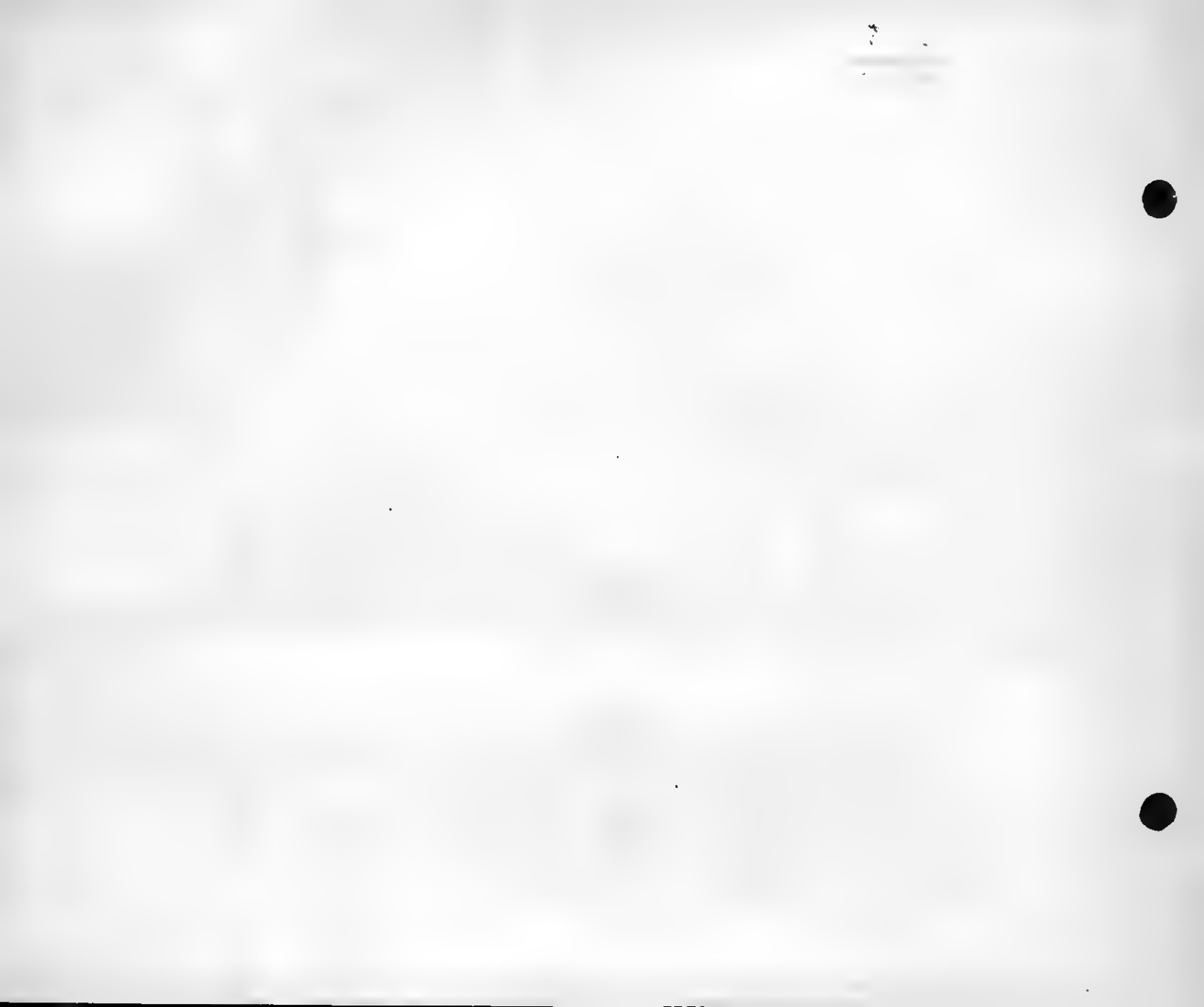
10617

Item 2 Film G392 8/1/67 kk

CERTIFICATE OF DEATH

10617

| | | | | | | | |
|--|------------------------------|---|------------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Talbot</u> | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> | | c LENGTH OF STAY IN 1b <u>24 5 mo</u> | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton J.</u> | | | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Masonic Homes (Bonnie Blair)</u> | | | | d STREET ADDRESS <u>15 Harrison Street</u> | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>CLAYTON</u> Last <u>Harris</u> | | | | 4 DATE OF DEATH Month <u>8</u> Day <u>12</u> Year <u>1967</u> | | | |
| 5 SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>8-3-1876</u> | | 9 AGE (in years lost birthday) <u>91</u> yrs | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS. Months Days Hours Min |
| 10a. JSUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLP Telephone</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>New Market Md.</u> | | 11 BIRTHPLACE (County & State, or foreign country) <u>USA</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13 FATHER'S NAME <u>Alexander Hall Harris</u> | | | | 14 MOTHER'S MAIDEN NAME <u>Nancy Hensley</u> | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16 SOCIAL SECURITY NO <u>212-10-094</u> | | 17 INFORMANT <u>Mrs. Francis Masonic Home</u> | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>1200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>longtime heart failure</u> (c) <u>Pulmonary edema</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>August 11, 1967</u> to <u>August 11, 1967</u> that (I) (we) lost saw the deceased alive on <u>August 11, 1967</u> , and that death occurred at <u>1:30 AM</u> , from causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE <u>JAMES H. HAMED</u> | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>8/12/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>JAMES H. HAMED</u> | | | | 22d. ADDRESS <u>MASONIC HOME</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>Aug 15, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Easton Md</u> | |
| 24. FUNERAL DIRECTOR <u>W. Cook-Brooks Towson</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>AUG 14 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| CERTIFICATE OF DEATH | | | |
| 1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN lb 19 DAYS | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 21217 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS 921 WHATCOAT STREET | |
| 3. NAME OF DECEASED (Type or print) JAMES HENRY HARRISON | | 4. DATE OF DEATH AUGUST 22 19 67 | |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JULY 4, 1894 |
| 9a. AGE (In years last birthday) 73 | | 9b. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10b. KIND OF BUSINESS OR IND. STRY ASPHALT BLOCK CO. | |
| 11. BIRTHPLACE (County & State, or foreign country) ANNE ARUNDEL CO. MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME GEORGE HARRISON | | 14. MOTHER'S MAIDEN NAME MAGGIE MN: UNKNOWN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I | | 16. SOCIAL SECURITY NO. 218 09 31 25 | |
| 17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CHRONIC PYELONEPHRITIS DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHOPNEUMONIA. ARTERIOSCLEROTIC HEART DISEASE | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (X) (this hospital) attended the deceased from 8/3/67 , 19 67 , to 8/22/67 , 19 67 , that (X) (we) last saw the deceased alive on 8/22/67 , 19 67 , and that death occurred at 9:55 AM from causes and on the date stated above. | | | |
| 22a. SIGNATURE John D. Talbert | | 22b. DATE SIGNED 8/23/67 | |
| 22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D. | | 22d. ADDRESS VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 8-28-67 | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND |
| 24. FUNERAL DIRECTOR Wm. Kelso Funeral Home | | 25a. REC'D BY REGISTRAR AUG 25 1967 | |
| ADDRESS 1348 N. Calhoun St. Baltimore, Md. | | 25b. REG STRAPS SIGNATURE John D. Talbert | |

TO HOSPITAL death, Page 4 TO FUNERAL director, page 3 TO BE FILED WITH THE STATE DEPT. OF HEALTH PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT, WITHIN 72 HOURS AFTER DEATH.

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER DEATH BY THE ATTENDING PHYSICIAN. THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER DEATH BY THE ATTENDING PHYSICIAN.

NOTE: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10619

10619

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 300 Alleghany Ave. | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 300 Alleghany Ave. a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Lydia E. Hartley First Middle Last 4. DATE OF DEATH August 25, 1967 Month Day Year | | 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH May 9, 1893 1883 9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker 13. FATHER'S NAME Benjamin Snyder | | 10b. KIND OF BUSINESS OR INDUSTRY 214-20-0744 D 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 214-20-0744D | | 17. INFORMANT Address Mrs. Calvin Van Horn (Daughter) Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): INANITION + DEHYDRATION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b): MULTIPLE CEREBROVASCULAR ACCIDENTS DUE TO (c): CEREBRAL + GENERALIZED ATHEROSCLEROSIS | | INTERVAL BETWEEN ONSET AND DEATH 1 WIC 2 YEARS YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/22/1962 to 8/25/1967 , that (I) (we) saw the deceased alive on 8/25/1967 , and that death occurred 10:00 AM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Donald L. Somerville M.D. | | 22b. DATE SIGNED 8/26/67 | |
| 22c. PHYSICIAN'S NAME (Type) DONALD L. SOMERVILLE | | 22d. ADDRESS 25 W. PA. AVE TOWSON, MD 21264 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Aug. 28, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery | | 23d. LOCATION (City, town or county) (State) Towson, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Eugenia V. Seitz Seitz Funeral Home Baltimore, Md. 21212 | | 25a. REC'D BY REGISTRAR AUG 28 1967 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10620

CERTIFICATE OF DEATH

10620

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1223 Birch Ave.</u> | | d. STREET ADDRESS <u>1223 Birch Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Florence M. Hartman</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/19/79</u> |
| 9. AGE (In years last birthday) <u>88</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Harry Paul</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary C. Weil</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Evelyn Rubio</u> | | Address <u>1223 Birch Ave.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10-7-84</u> , 19 <u> </u> , to <u>8-27-67</u> , 19 <u> </u> , that (I) (we) lost saw the deceased die on <u>8-27-67</u> , 19 <u> </u> , and that death occurred at <u> </u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Harry G. Gumbel</u> | | 22b. DATE SIGNED <u>8-28-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Harry Gumbel</u> | | 22d. ADDRESS <u>4605 Edmondson Ave.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>8/30/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u> | 23d. LOCATION (City or town) (County) (State) <u>Baltimore Md</u> |
| 24. FUNERAL DIRECTOR <u>James J. Sulzberger Jr.</u> | | 25a. RECEIVED BY REGISTRAR DATE <u>AUG 29 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>James J. Sulzberger Jr.</u> | | 25c. REGISTRAR'S SIGNATURE <u>James J. Sulzberger Jr.</u> | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

10621

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10621

| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium 21093 | | c. LENGTH OF STAY IN 1b 5 yrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 229 W. Timonium Road | | e. STREET ADDRESS 229 W. Timonium Road | |
| 3 NAME OF DECEASED (Type or print) HELEN HARDIN HAUGHTON | | 4 DATE OF DEATH Month Day Year August 4, 19 67 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Mar. 17, 1902 |
| 9 AGE (In years and birthday) 65 yrs | | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME Robert C. Hardin | | 14 MOTHER'S MAIDEN NAME Lettie Pasterfield | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16 SOCIAL SECURITY NO 7 | |
| 17 INFORMANT Holden R. Houghton, Timonium, Md. | | Address | |
| 18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street city, town, or county) | |
| 22. DATE SIGNED 8/4/67 | | | |
| 23a BURIAL CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Aug. 8, 67 | 23c. NAME OF CEMETERY OR CREMATORY Spring Hill | 23d. LOCATION (City or Town) (County) (State) Easton, Md. |
| 24 FUNERAL DIRECTOR Wm. Cook-Brooks Towson, Towson, Md. 21204 | | 25a. REC'D BY REGISTRAR DATE AUG 8 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10622

10622

| | | | | | | | |
|--|------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | c. LENGTH OF STAY IN 1b <u>2 years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2703 Waco Court #8</u> | | | | d. STREET ADDRESS <u>2703 Waco Ct. 8</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>HERBERT</u> Middle <u>Heft</u> Last <u>Heft</u> | | | | 4. DATE OF DEATH Month <u>Aug</u> Day <u>22</u> Year <u>1967</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>3/30/1925</u> | | 9. AGE (In years, last birthday) <u>42 yrs.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public Relations</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Basketball</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>HARRY Heft</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ROSE TARANSKY</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>519-24-0006</u> | | 17. INFORMANT <u>WIFE - Mrs. Shirley H. Heft</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> DUE TO (b) <u>Rheumatic Cl Disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>7</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>August, 1965</u> , to <u>Aug 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 1967</u> , and that death occurred at <u>5:45</u> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Samuel Legum</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. _____ | | 22b. DATE SIGNED <u>8-22-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>SAMUEL LEGUM, M.D.</u> | | | | 22d. ADDRESS <u>1261 E. North Ave. Baltimore 2 Md</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>8/23/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>B'NAT ISRAEL</u> | | 23d. LOCATION (City, town or county) (State) <u>Baltimore, MARYLAND</u> | |
| 24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 DEIST., RD.</u> | | | | 25a. REC'D BY REGISTRAR <u>AUG 25 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10623

10623

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> c. LENGTH OF STAY IN It <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>418 High Meadow Rd.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Reisterstown</u> d. STREET ADDRESS <u>418 High Meadow Road</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Mary E. Henn</u> First Middle Last | | | | 4. DATE OF DEATH <u>Aug. 3 1967</u> Day Month Year | | | |
| 5. SEX <u>female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>April 2, 1905</u> | |
| 9. AGE (In years last birthday) <u>62</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> | |
| 10c. CITIZEN OF WHAT COUNTRY <u>United States</u> | | | | 12. CITIZEN OF WHAT COUNTRY <u>United States</u> | | | |
| 13. FATHER'S NAME <u>Martin Cloney</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Rackenberg</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u> | | | | 16. SOCIAL SECURITY NO. <u>none</u> | | | |
| 17. INFORMANT <u>Mr. James C. Henn</u> | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Arteriosclerosis - generalized</u> (b) <u>Uremia</u> (c) <u>3 months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (e) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) <u>Reisterstown</u> | | | | 20g. (County) <u>MD</u> | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>February 1967</u> to <u>August 3, 1967</u> that (I) (we) last saw the deceased alive on <u>July 31, 1967</u> and that death occurred at <u>11904 Reisterstown Rd Reisterstown Md</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Clarence E Mc Williams</u> M.D. | | | | 22b. DATE SIGNED <u>August 3 1967</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Clarence Mc Williams</u> | | | | 22d. ADDRESS <u>11904 Reisterstown Rd Reisterstown Md</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Aug. 5, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u> | | 23d. LOCATION (City, town or county) <u>Glen Burnie A.A. Co Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>169 RIVIERA DR A4C</u> | | | | 25a. REC'D BY REGISTRAR <u>AUG 7 1967</u> | | | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u> | | | | | | | |

10624

10624

MEDICAL CERTIFICATION

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10625

CERTIFICATE OF DEATH

10625

| | | | | | |
|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | c. LENGTH OF STAY IN IB 3 months | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arm | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | | d. STREET ADDRESS Box 420 Notchcliff Rd. | | e. IS RES. DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Max Middle Henschel Last | | | 4. DATE OF DEATH Month 8 Day 18 Year 67 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/10/1899 | | 9. AGE (In years last birthday) yrs 68 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registrar - retired | | 10b. KIND OF BUSINESS OR INDUSTRY Shipping Assn. | 11. BIRTHPLACE (County & State, or foreign country) New York, N.Y. | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME Morris Henschel | | | 14. MOTHER'S MAIDEN NAME Ida ? | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | | 16. SOCIAL SECURITY NO. 130-18-4202 | 17. INFORMANT Family records Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia DUE TO Chronic myelogenous leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that the (this hospital) attended the deceased from 8/18 , 19 67 , to 8/18 , 19 67 , that he (we) lost saw the deceased alive on 8/18 , 19 67 , and that death occurred 5:05p M, from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE  | | | 22b. DATE SIGNED August 19, 1967 | | |
| 22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M. D. | | | 22d. ADDRESS 7620 York Road, Towson 4, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
| Removal Burial Aug. 22, 1967 | | Maple Grove Cemetery New Gardens, N.Y. | | | |
| 24. FUNERAL DIRECTOR John Jurns' Sons, Towson, Maryland | | | 25. REC'D BY REGISTRAR DATE AUG 21 1967 | 26. REGISTRAR'S SIGNATURE  | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10626

CERTIFICATE OF DEATH

10626

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|--|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2021 Englewood Ave. 21207 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Irene Middle R. Last Hertsch | | 4 DATE OF DEATH Month August Day 27 Year 1967 | |
| 5. SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH July 23, 1895 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | 9 AGE (In years last birthday) 72 yrs |
| 11 BIRTHPLACE (County & State, or foreign country) Baltimore Md. | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME George Miller | | 14 MOTHER'S MAIDEN NAME Annie Keller | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16 SOCIAL SECURITY NO. none | |
| 17 INFORMANT Frank F. Hertsch Sr. | | Address 2021 Englewood Ave #7 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4344 IMMEDIATE CAUSE (a) Cardiac Failure DUE TO (b) Cardiac Decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | INTERVAL BETWEEN ONSET AND DEATH Mar 1, 1963 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I (this hospital) attended the deceased from Mar. 1, 1963 to August 26, 1967 , that I (we) last saw the deceased alive on August 26, 1967 , and that death occurred at _____ M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE George E. Shannon | | 22b. DATE SIGNED Aug. 28, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) George E. Shannon M.D. | | 22d. ADDRESS 412 Medical Arts Bldg | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/30/67 | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn | 23d. LOCATION (City or Town) (County) (State) Woodlawn Balbo Co Md. |
| 24. FUNERAL DIRECTOR Foring Myers | | 25a. REC'D BY REGISTRAR 8728 Liberty Rd | |
| 25b. REGISTRAR'S SIGNATURE Randalistown Md | | 25c. DATE AUG 30 1967 | |

10627

CERTIFICATE OF DEATH

10627

| | | | |
|--|---|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u> | | c. LENGTH OF STAY in 1b <u>26 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTIMORE County Gen. Hosp.</u> | | d. STREET ADDRESS <u>16 N. Collington Ave.</u> | |
| 3 NAME OF DECEASED (Type or print) First <u>JACOB</u> Middle <u>—</u> Last <u>HESS</u> | | 4. DATE OF DEATH Month <u>8</u> Day <u>8</u> Year <u>1967</u> | |
| 5 SEX <u>M</u> | 6 COLOR OR RACE <u>CAUC.</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>7/4/195</u> |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BLACKSMITH</u> | | 10b KIND OF BUSINESS OR INDUSTRY <u>AM. SUGAR REF. CO.</u> | 11 BIRTHPLACE (County & State or foreign country) <u>RUSSIA</u> |
| 13 FATHER'S NAME <u>SIDNEY CHUSIN</u> | | 14 MOTHER'S MAIDEN NAME <u>HILDA ZELINS</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16 SOCIAL SECURITY NO <u>UNKNOWN</u> | |
| 17 INFORMANT <u>MRS. LILLIAN HESS, 16 N. COLLINGTON AVENUE</u> | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO (b) <u>myocardial damage</u> DUE TO (c) <u>possible ventricular fibrillation</u> | | | INTERVA. BETWEEN ONSET AND DEATH <u>Not known</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Presumably a multi-system disease, pericarditis, nodules</u> | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>not injured</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/13/67</u> , 19 <u>67</u> to <u>8/8/67</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>4pm 8/8/1967</u> , and that death occurred at <u>9p</u> M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>M. KHODA</u> | | 22b. DATE SIGNED <u>8/8/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>KHODA</u> | | 22d. ADDRESS <u>BALTIMORE County GENERAL HOSPITAL</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>8/10/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>(ANSHE EMLAH) - AITZ CHAIM</u> | 23d. LOCATION (City or town) (County) (State) <u>BALTIMORE, MARYLAND</u> |
| 24 FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REIST., RD.</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| 25b. REGISTRAR'S SIGNATURE | | DATE <u>AUG 14 1967</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

| 10626 | | | | | | | | | | 20628 | | | | | | | | | |
|---|--|---------------------------|--|--|--|---------------------------------------|--|--|--|--|--|---|--|--|--|--|--|--|--|
| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| Reg. Dist. No. | | | | | | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | | | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u> | | | | | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md. DUNDALK</u> | | | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paradise Nursing Home</u> | | | | | | | | | | d. STREET ADDRESS <u>24 Leeway</u> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Sevena</u> Middle <u>D.</u> Last <u>Hicks</u> | | | | | | | | | | 4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>1967</u> | | | | | | | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Aug. 22, 1876</u> | | 9. AGE (In years last birthday) <u>90</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u> | | | | | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>KENTUCKY</u> | | | | | | | | | |
| 11. BIRTHPLACE (State or foreign country) <u>KENTUCKY</u> | | | | | | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | | | |
| 13. FATHER'S NAME <u>GEORGE CARROLL</u> | | | | | | | | | | 14. MOTHER'S MAIDEN NAME <u>MURRINS</u> | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u> | | | | | | | | | | 16. SOCIAL SECURITY NO. <u>214-36-2916</u> | | | | | | | | | |
| 17. INFORMANT <u>MRS MARY HICKS</u> | | | | | | | | | | Address <u>24 LEeway</u> | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | | | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | | | 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that I attended the deceased from <u>8/8 7/19</u> , 19 <u>67</u> , to <u>8/16</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>8/8</u> , 19 <u>67</u> , and that death occurred at <u>8:55</u> A.M., from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>D. Sorongon</u> M.D. | | | | | | | | | | ADDRESS (Street, city or town, state) <u>3915 Hollins Ferry Rd. BALTIMORE Md. 21227</u> | | | | | | | | | |
| DATE SIGNED <u>8/16/67</u> | | | | | | | | | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>DOMINGO C. SORONGON M.D.</u> | | | | | | | | | | BALTIMORE Md. 21227 | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | | | | | | | 22b. DATE THEREOF <u>8/18/67</u> | | | | | | | | | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u> | | | | | | | | | | 22d. LOCATION (City, town, or county) (State) <u>COLGATE MD</u> | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME - DUNDALK MD.</u> | | | | | | | | | | ADDRESS | | | | | | | | | |
| 24a. REC'D BY REGISTRAR <u>AUG 21 1967</u> | | | | | | | | | | 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

10629

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10629

| | | | | | | | |
|---|---------------------------|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kingsville | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kingsville | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Belair Road | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Jacob French Hildt First Middle Last | | | | 4. DATE OF DEATH Aug. 22 1967 Month Day Year | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Jan. 4, 1894 | | 9. AGE (In years, last birthday) 73 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer | | 10b. KIND OF BUSINESS OR INDUSTRY Self | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Phillip I. Hildt | | | | 14. MOTHER'S MAIDEN NAME Sarah E. Emerick | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Ruth Williams Hildt | | Address Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1956 to Aug. 1967 , that (I) (we) last saw the deceased alive on Aug 2, 1967 , and that death occurred at 4:45 M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE William A. Tyson | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 8-22-67 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. William A. Tyson | | | | 22d. ADDRESS Kingsville Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8-25-67 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine | | 23d. LOCATION (City, town or county) (State) Woodlawn, Md. | |
| 24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. | | | | 25a. REC'D BY REGISTRAR AUG 28 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |
| 6500 York Rd. Baltimore, Md. 21212 | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

| | | | |
|--|--------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Baltimore</u> | | c. LENGTH OF STAY IN ID <u>9 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Med. Center</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>George</u> Last <u>Himmer</u> | | 4. DATE OF DEATH Month <u>8</u> Day <u>25</u> Year <u>1967</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>CAU</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-25-28</u> |
| 9. AGE (In years last birthday) <u>39</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Division Manager</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Bottled Gas Industry</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Conrad Himmer</u> | | 14. MOTHER'S MAIDEN NAME <u>Helen Rosina Herget</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>217-24-0087</u> | |
| 17. INFORMANT (with Address) <u>Mrs. Mary Lee Himmer</u> | | <u>RED, Box #135</u> <u>Huntingtown Md. 20639</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration pneumonia</u> (c) <u>Metastatic Nasopharyngeal Carcinoma</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>5'</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>aspiration pneumonia</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NONE</u> | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>NONE</u> | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>NONE</u> p.m. <u>49</u> | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>NONE</u> | |
| 20f. (City or town) (County) (State) <u>NONE</u> | | 21. I certify that (I) (this hospital) attended the deceased from <u>8/15</u> , 19 <u>67</u> , to <u>8/25</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8/25</u> , 19 <u>67</u> , and that death occurred at <u>120</u> M, from the causes and on the date stated above. | |
| 22a. SIGNATURE <u>M. ALONZO, M.D.</u> | | 22b. DATE SIGNED <u>8/25/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>M. ALONZO, M.D.</u> | | 22d. ADDRESS <u>GBMC Bal Ho., Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>August 28, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>Joseph William Foster</u> | | 25a. REC'D BY REGISTRAR <u>AUG 28 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | 25c. ADDRESS <u>W. Broadway & Williams St. Bal Air, Maryland 21014</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10631

CERTIFICATE OF DEATH

10631

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 21206 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206 d. STREET ADDRESS 6102 Springwood Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Lillian Prinz HISLEY | | | | 4. DATE OF DEATH Month Day Year August 24, 1967 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH October 4, 1882 | |
| 9. AGE (In years most birthday) 84 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of work ing life, even if retired) Homemaker | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Prinz | | | | 14. MOTHER'S MAIDEN NAME Wilhelmina Koerner | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO - | | 17. INFORMANT Mrs. Majorie Smith-6102 Springwood Avenue | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism. DUE TO Carcinoma of ovary with metastasis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/13/ , 19 67 , to 8/24/67 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/13/67 , 19 67 , and that death occurred at 10:25 , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Freidoon Malek, M.D. | | | | 22b. DATE SIGNED August 24, 1967 | | 22c. PHYSICIAN'S NAME (Type) Freidoon Malek, M.D. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 8-28-67 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR John C. Miller Inc-7415 Belair Road-21206 | | | | 25. RECEIVED BY REGISTRAR Aug 29 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10632

CERTIFICATE OF DEATH

10632

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Thomas Lane</u> | | d. STREET ADDRESS <u>St. Thomas Lane</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Hoff</u> Last <u>Hoff</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 26, 1869</u> |
| 9. AGE (in years (on birthday) yrs) <u>98</u> | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Co. Md.</u> | | 12. CITIZENSHIP OF WHAT COUNTRY <u>USA</u> | |
| 13. FATHER'S NAME <u>William Stangler</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Winkler</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>218-54-4677</u> | |
| 17. INFORMANT <u>Mrs. Henry Hoff</u> | | Address <u>Owings Mills, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Mesenteric Thrombosis</u> 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Arteriosclerotic C.V. Disease</u> (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u> </u> years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 8</u> , 19 <u>67</u> , to <u>Aug. 8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug. 8</u> , 19 <u>67</u> , and that death occurred at <u>1 P.M.</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Martin E. Strobel</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>Martin E. Strobel, M.D.</u> | | 22d. ADDRESS <u>418 Main St. Reisterstown, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Aug. 11, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Owings Mills, Md.</u> |
| 24. FUNERAL DIRECTOR <u>J. F. Eline & Sons</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| ADDRESS <u>Reisterstown, Md.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

2000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10633

CERTIFICATE OF DEATH

10633

| | | | | | |
|--|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore, Md.</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u> | | c. LENGTH OF STAY IN 1b <u>DOA</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hospital</u> | | | d. STREET ADDRESS <u>6011 Gwynn Oak Ave.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <u>Matthew T HOGAN</u> | | | 4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>1967</u> | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-14-07</u> | | 9. AGE (In years last birthday) <u>59</u> yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Insurance adjuster Balto Co.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Thomas Hogan</u> | | | 14. MOTHER'S MAIDEN NAME <u>Molly Deveney</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO <u>Yes</u> | 17. INFORMANT <u>Betty M. Hogan - 6011 Gwynn Oak Avenue</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>Cornary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Old Coronary in May 66</u> (c) <u>Coronary Insufficiency Continued</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 17, 1966</u> to <u>8-5</u> , 1967, that (I) (we) last saw the deceased alive on <u>8-4</u> 19 <u>67</u> and that death occurred at <u>10:45 AM</u> , from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <u>Dr. Flor Y. Ruffin</u> | | | 22b. DATE SIGNED <u>8-5-67</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. Flor Y. Ruffin</u> | | | 22d. ADDRESS <u>4509 Liberty Heights Ave.</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>8-9-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u> | | 23d. LOCATION (City or town) (County) (State) <u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>Ellsworth Armacost-4600 Liberty Hghts. Ave.</u> | | | 25a. REC'D BY REGISTRAR <u>AUG 7 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

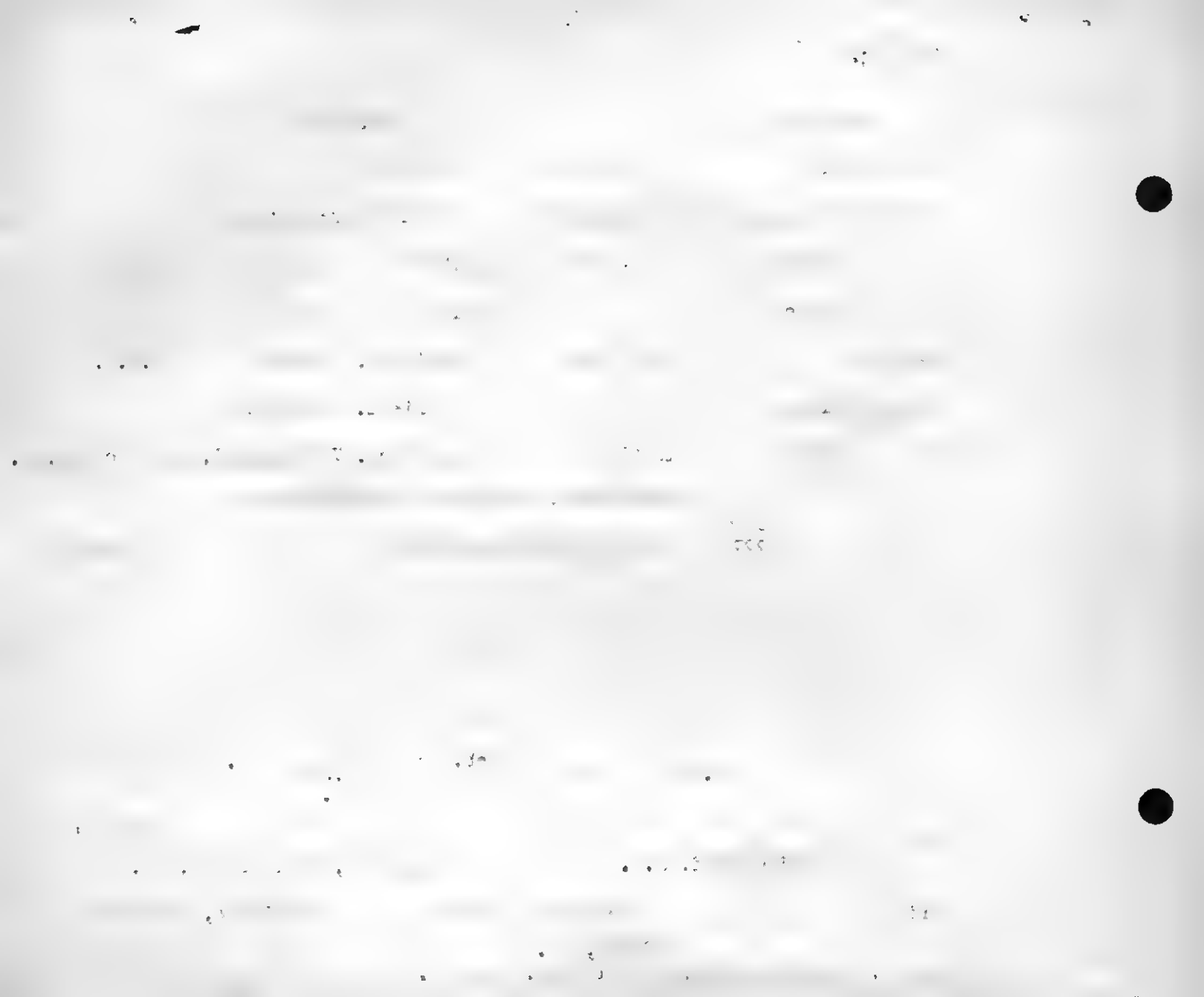
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10634

CERTIFICATE OF DEATH

10634

| | | | | | | | |
|--|----------------------------------|---|-------------------------------------|---|--|---|-------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 194 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital | | | | d. STREET ADDRESS 2911 Scherer Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) EDWARD | | First Middle Last JACOB HOLMES | | 4. DATE OF DEATH Month Day Year August 26 1967 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/12/06 | | 9. AGE (In years lost birthday) 60 yrs | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur | | 10b. KIND OF BUSINESS OR INDUSTRY Taxi Cabs | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Edward Holmes | | | | 14. MOTHER'S MAIDEN NAME Marie E. Rielender | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWII | | 16. SOCIAL SECURITY NO. 216 09 98 70 | | 17. INFORMANT Address Clinical Rcds, VA Hospital, Fort Howard, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA WITH METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. TO LYMPH NODES AND SKIN (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that 10 (this hospital) attended the deceased from Feb. 13 , 19 67 to Aug. 26 19 67 that (1) we saw the deceased alive on Aug. 26 19 67 , and that death occurred at 2:45 AM, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Ahmed Kutty | | | | M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED 8/26/67 | |
| 22c. PHYSICIAN'S NAME (Type) AHMED KUTTY, M.D. | | | | 22d. ADDRESS VA Hospital, Fort Howard, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/29/67 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial | | 23d. LOCATION (City or town) (County) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR CHARLES L. STEVENS FUNERAL HOME 1501 E. Fort St. | | | | 25a. REC'D BY REGISTRAR AUG 28 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10635

CERTIFICATE OF DEATH

10635

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>---</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u> | | d. STREET ADDRESS <u>3108 Remington Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>MARGARET</u> Last <u>HOOPER</u> | | 4. DATE OF DEATH Month <u>Aug.</u> Day <u>31</u> Year <u>1967</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>CAU</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9/14/18</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR CLOTHING</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u> | 9. AGE (In years last birthday) <u>48</u> yrs |
| 11. BIRTHPLACE (County & State, or foreign country) <u>CLARKSBURG, W. VA.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Olivero</u> | | 14. MOTHER'S MAIDEN NAME <u>THESEDA OLIVER</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>235-10-1719</u> | |
| 17. INFORMANT <u>BARBARA J. HAWES-4108 FALLS RD</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hydropneumothorax - respiration difficulty.</u> DUE TO (b) <u>Cancer of breast metast. to right humerus</u> DUE TO (c) <u>lungs</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8/10/1967</u> , to <u>8/31/1967</u> , that (I) (we) last saw the deceased alive on <u>8/30/1967</u> , and that death occurred at <u>4:15 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>N. Eftakhari</u> | | 22b. DATE SIGNED <u>8-31-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Nasser Eftakhari</u> | | 22d. ADDRESS <u>GBMC 8701 N. Charles St. Balto. 21204</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Sept 5, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Balto National</u> | 23d. LOCATION (City or Town) (County) (State) <u>Fredrick Rd. Md.</u> |
| 24. FUNERAL DIRECTOR <u>Austin E. Donovan-3818 Roland Ave</u> | | 25a. REC'D BY REGISTRAR DATE <u>SEP 5 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u> | |



20636

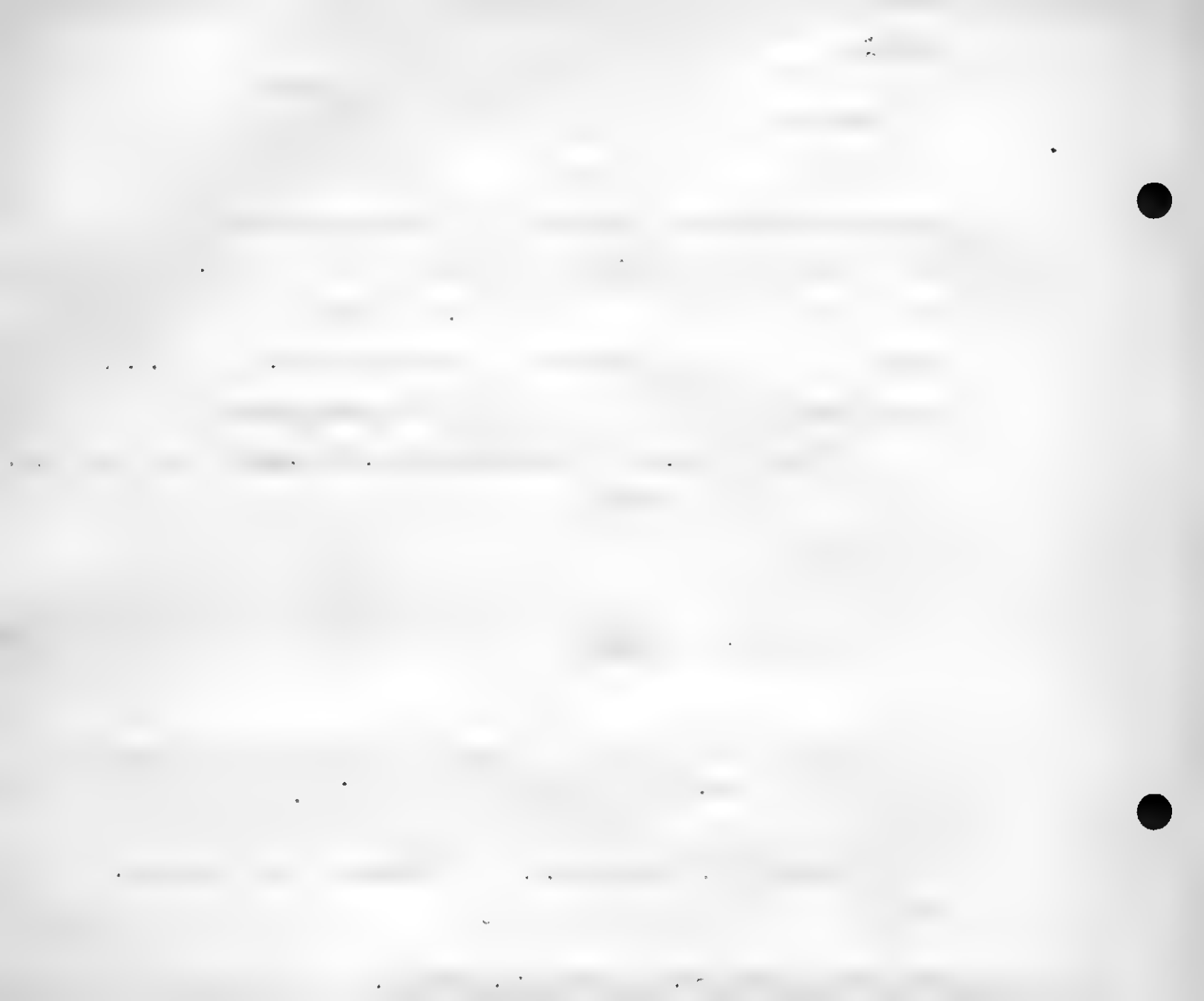
| | | | |
|---|------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | c. LENGTH OF STAY IN 1b BALTIMORE | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 396 - Rt. 15 - Balto., Md. 20 | | d. STREET ADDRESS Box 396 - Rt. 15. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) MINNIE - HORNER | | 4. DATE OF DEATH Month 8 - Day 21 - Year 1967 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-23-1887 |
| 9. AGE (In years last birthday) 79 yrs | | 10. IF UNDER 1 YEAR Months 7 Days 9 | 11. IF UNDER 24 HRS Hours 11 Min 23 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES LADY | | 10b. KIND OF BUSINESS OR INDUSTRY MARYLAND | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME MAX SCHRECK | | 14. MOTHER'S MAIDEN NAME CAROLINE MUTH. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 22022 9896A | |
| 17. INFORMANT Mr. Wm. C. Horner - Box 396 Rt. 15 Balto. 20 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Art. sclerotic cerebrovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 yrs DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 10, 1964 to Aug 21, 1967 that (I) (we) last saw the deceased alive on Aug 21, 1967 , and that death occurred at 3 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Louis Somenoff | | 22b. DATE SIGNED 8/21/67 | |
| 22c. THIS CLAN'S NAME (Type) LOUIS SOMENOFF | | 22d. ADDRESS 2108 OREMS RD, BALTO MD 21220 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 8-24-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE CEM. | | 23d. LOCATION (City, town, or county) (State) BALTO. Mo. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Walter Miller - 2334 Jefferson St. | | 25a. REC'D BY REGISTRAR AUG 22 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| 10637 | | CERTIFICATE OF DEATH | |
| 10637 | | 10637 | |
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| c. LENGTH OF STAY IN b. 56 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital | | e. STREET ADDRESS 211 Wickham Road | |
| 3. NAME OF DECEASED (Type or print) HAROLD HILBERT MYLAND | | 4. DATE OF DEATH Month Aug. Day 11 Year 67 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 10, 1904 |
| 9. AGE (In years last birthday) yrs 63 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | |
| 11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Maurice Myland | | 14. MOTHER'S MAIDEN NAME Elizabeth McLaughlin | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes P1-28 | | 16. SOCIAL SECURITY NO 218 14 54 13 | |
| 17. INFORMANT Clinical Recds. VA Hospital, Fort Howard, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO (b) (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC PULMONARY EMPHYSEMA | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | |
| 21. I certify that (X) (this hospital) attended the deceased from June 16, 1967 , to Aug 11, 1967 , that (X) (we) last saw the deceased alive on Aug. 11, 1967 , and that death occurred at 5:20 P. from causes on and on the date stated above. | | | |
| 22a. SIGNATURE <i>Deogracias V. Faustino, M.D.</i> M.D. | | 22b. DATE SIGNED 8/12/67 | |
| 22c. PHYSICIAN'S NAME (Type) DEOGRACIAS V. FAUSTINO, M.D. | | 22d. ADDRESS VA Hospital, Fort Howard, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/14/67 | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery | 23d. LOCATION (City or Town) (County) (State) Baltimore Maryland |
| 24. FUNERAL DIRECTOR MacKabb Funeral Home Fred. and S. Wade A.C. Balto Md. | | 25a. REC'D BY REGISTRAR DATE AUG 14 1967 | |
| 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10638

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10638

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown c. LENGTH OF STAY IN '66 Hour d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 30 Main Street | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown d. STREET ADDRESS 213 Main Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) JOAN MAS INGLE First Middle Last | | 4. DATE OF DEATH August 17, 1967 Month Day Year | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-24-34 9. AGE (in years last birthday) 32 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Gordon A. Sutton | | 14. MOTHER'S MAIDEN NAME Cleo Smith | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO 219-30-3958 | |
| 17. INFORMANT Mr. Gordon A. Sutton | | Address 5926 Falls Rd. 21209 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aortic insufficiency with massive left ventricular hypertrophy and dilatation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4211 (b) XXXXXX DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> at work hot While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles S. Springate, M.D. EXAMINER'S NAME (Type) | | 22. DATE SIGNED August 17, 1967 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/19/67 | 23c. NAME OF CEMETERY OR CREMATORY Clynmalira Cemetery | 23d. LOCATION (City or town) (County) (State) Baltimore County Md. |
| 24. FUNERAL DIRECTOR Wm. Cook-Brooks ADDRESS Towson 1050 York Rd. 21204 | | 25a. REC'D BY REGISTRAR AUG 24 1967 25b. REGISTRAR'S SIGNATURE Charles S. Springate | |

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10639

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10639

| | | | |
|--|--|---|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | c. LENGTH OF STAY IN 1b Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | d. STREET ADDRESS Box 284 Manor Road | |
| 3 NAME OF DECEASED (Type or print) OSCAR L. Isennock Jr. | | 4 DATE OF DEATH August 22 19 67 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 8/12/1933 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | 12 CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13 FATHER'S NAME Oscar L. Isennock Sr. | | 14 MOTHER'S MAIDEN NAME Bertha M. Unkart | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16 SOCIAL SECURITY NO none | 17 INFORMANT Mr. Oscar L. Isennock Sr. Address same |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fatty liver DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Russell S. Fisher, M.D. | | 22. DATE SIGNED August 23, 1967 | |
| EXAMINER'S NAME (Type) Russell S. Fisher, M.D. | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/26/67 | 23c. NAME OF CEMETERY OR CREMATORY Moreland Park Cem. | 23d. LOCATION (City or town) (County) (State) Balto, Md. |
| 24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. | | 25a. RECD. BY REGISTRAR AUG 24 1967 25b. REGISTRAR'S SIGNATURE Charles Judge | |

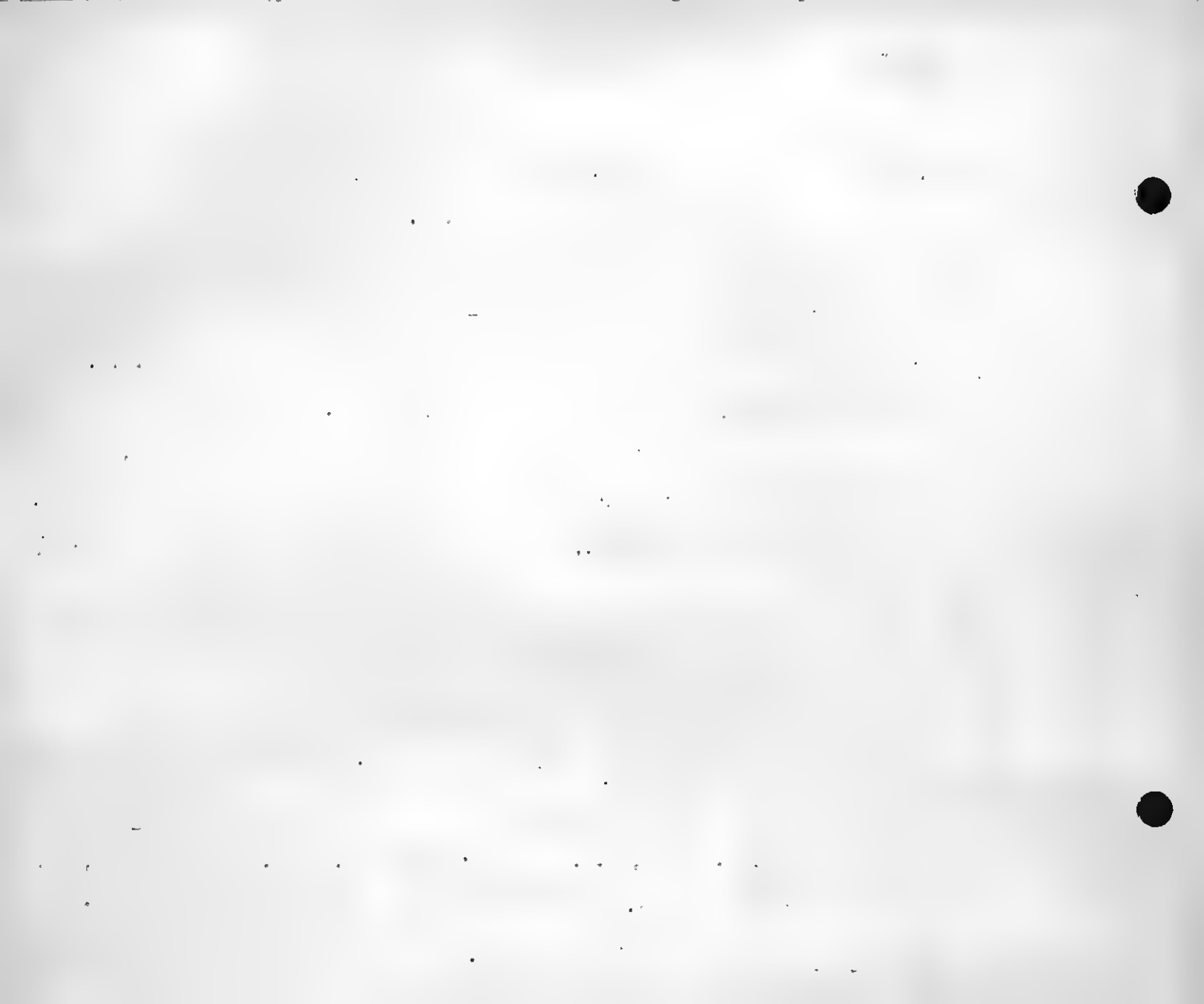
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| <div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>10640</p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>10640</p> </div> </div> | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|
| <p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Baltimore</u> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u></p> <p>c. LENGTH OF STAY IN 1D <u>6 Months</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood State Hospital</u></p> | | | | | <p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Knoxville</u></p> <p>d. STREET ADDRESS <u>Rt. 1, Box 141</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> | | | | |
| <p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>Wayne</u> Middle <u>Edward</u> Last <u>Jackson</u></p> | | | | | <p>4. DATE OF DEATH</p> <p>Month <u>8</u> Day <u>12</u> Year <u>1967</u></p> | | | | |
| <p>5. SEX <u>male</u></p> <p>6. COLOR OR RACE <u>Negro</u></p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> | | | | | <p>8. DATE OF BIRTH <u>6-16-65</u></p> <p>9. AGE (in years last birthday) <u>2</u> yrs.</p> <p>IF UNDER 1 YEAR: Months <u>2</u> Days <u>12</u> Hours <u>19</u> Min. <u>67</u></p> | | | | |
| <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u></p> <p>10b. KIND OF BUSINESS OR INDUSTRY <u>None</u></p> | | | | | <p>11. BIRTHPLACE (County & State, or foreign country) <u>Frederick, Maryland</u></p> <p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p> | | | | |
| <p>13. FATHER'S NAME <u>Charles Edward Jackson</u></p> | | | | | <p>14. MOTHER'S MAIDEN NAME <u>Catherine E. Spriggs</u></p> | | | | |
| <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u></p> | | | | | <p>16. SOCIAL SECURITY NO. <u>None</u></p> | | | | |
| <p>17. INFORMANT <u>Rosewood Records, Owings Mills, Maryland</u></p> | | | | | <p>Address</p> | | | | |
| <p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Acute Meningitis</u></p> <p>34711</p> <p>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</p> <p>DUE TO (b) <u>Hydrocephalus</u></p> <p>DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> | | | | | | | | | |
| <p>INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u></p> <p><u>26 mos.</u></p> | | | | | | | | | |
| <p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> | | | | | | | | | |
| <p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p> | | | | | | | | | |
| <p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour <u>19</u> a.m. <u>19</u> p.m.</p> <p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f. (City or town) (County) (State)</p> | | | | | | | | | |
| <p>21. I certify that <u>NO</u> (this hospital) attended the deceased from <u>1-24</u>, 19<u>67</u>, to <u>8-12</u>, 19<u>67</u>, that <u>OK</u> (we) last saw the deceased alive on <u>8-7-67</u>, 19<u>67</u>, and that death occurred at <u>9:50</u> PM, from the causes and on the date stated above.</p> | | | | | | | | | |
| <p>22a. SIGNATURE <u>Richard A. Jones</u> M.D.</p> <p>22b. DATE SIGNED <u>8-14-67</u></p> | | | | | | | | | |
| <p>22c. PHYSICIAN'S NAME (Type) <u>Richard A. Jones, M.D.</u></p> <p>22d. ADDRESS <u>Rosewood St. Hosp., Owings Mills, Md.</u></p> | | | | | | | | | |
| <p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p> <p>23b. DATE THEREOF <u>8/17/67</u></p> <p>23c. NAME OF CEMETERY OR CREMATORY <u>Mary's Cemetery</u></p> <p>23d. LOCATION (City, town or county) (State) <u>Petersville Md.</u></p> | | | | | | | | | |
| <p>24. FUNERAL DIRECTOR <u>Facts Funeral Home</u> ADDRESS <u>Brunswick, Md.</u></p> <p>25a. REC'D BY REGISTRAR <u>AUG 16 1967</u></p> <p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p> | | | | | | | | | |

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

10641

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10641

| | | | |
|---|-----------------------------------|---|---|
| 1 PLACE OF DEATH a COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission a STATE Maryland b COUNTY Baltimore | |
| b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Dundalk | | c LENGTH OF STAY IN IB Dundalk | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 208 Riverview Ave. | | d STREET ADDRESS 208 Riverview Ave | |
| 3 NAME OF DECEASED (Type or print) Leo Janowitz | | 4 DATE OF DEATH Month August , Day 7 , Year 19 67 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Nov. 2, 1908 |
| 9 AGE (in years last birthday) 58 yrs | | 10 UNDER 1 YEAR Months 58 Days 58 Hours 58 Min 58 | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab driver | | 10b KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11 BIRTHPLACE (State or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME Edward Janowitz | | 14 MOTHER'S MAIDEN NAME ? | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16 SOCIAL SECURITY NO 218-03-2082 | |
| 17 INFORMANT Mrs. Madeline Janowitz | | Address 208 Riverview Ave. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4331 Acute Coronary Occlusion DUE TO (b) Chronic Alcoholism DUE TO (c) Chronic Alcoholism | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Alcoholism | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) | |
| 20c TIME OF DEATH (Month, Day, Year) Hour a.m. 19 p.m. 19 | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f (City or town) (County) (State) | |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22 DATE SIGNED 8/8/67 | |
| ACTUAL SIGNATURE Theodore C. Patterson EXAMINER'S NAME (Type) Theodore C. Patterson | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) 105 Main, Dundalk, Md. | |
| 23a BURIAL, CREMATION, REMOVAL, SPECIFY Burial | 23b DATE THEREOF 8/9/67 | 23c NAME OF CEMETERY OR CREMATORY Gardens of Faith | 23d LOCATION (City or town) (County) (State) Overlea, Md. |
| 24 FUNERAL DIRECTOR Ullrich Funeral Home Dundalk, Md. | | 25a REC'D BY REGISTRAR AUG 11 1967 | |
| 25b REGISTRAR'S SIGNATURE Charles Judge | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10642

CERTIFICATE OF DEATH

10642

| | | | |
|--|--|--|---|
| 1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admittance) a. STATE BALTIMORE MARYLAND | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN IS 50 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS 3704 GARRISON BLVD. | |
| 3 NAME OF DECEASED (Type or print) First JAMES Middle STEWART Last JENKINS | | 4 DATE OF DEATH Month AUGUST Day 3 Year 19 67 | |
| 5. SEX MALE | 6 COLOR OR RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/25/97 9 AGE (In years last birthday) 69 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LONG SHOREMAN | | 10b. KIND OF BUSINESS OR INDUSTRY LONG SHOREMAN | |
| 11 BIRTHPLACE (County & State, or foreign country) Richmond County VA. | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME DECEASED FLEET JENKINS | | 14. MOTHER'S MAIDEN NAME ROSE FISHER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II | | 16. SOCIAL SECURITY NO. 217 09 94 22 | |
| 17. INFORMANT VAH RECORDS FORT HOWARD, MARYLAND | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE GASTRIC DILATATION WITH PERFORATION DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CIRRHOSIS, LIVER BRONCHOPNEUMONIA | | | INTERVAL BETWEEN ONSET AND DEATH HOURS |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from JUNE 14 , 19 67 , to AUGUST 3 , 19 67 that (I) (we) last saw the deceased alive on AUGUST 3 , 19 67 , and that death occurred 10:45 AM from causes on and on the date stated above. | | | |
| 22a. SIGNATURE J. D. Talbert | | 22b. DATE SIGNED 8/4/67 | |
| 22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D. | | 22d. ADDRESS VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 8-7-67 | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND |
| 24 FUNERAL DIRECTOR MORTON AND DYETT | | 25a. REC'D BY REGISTRAR AUG 7 1967 | 25b. REGISTRAR'S SIGNATURE Phyllis Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

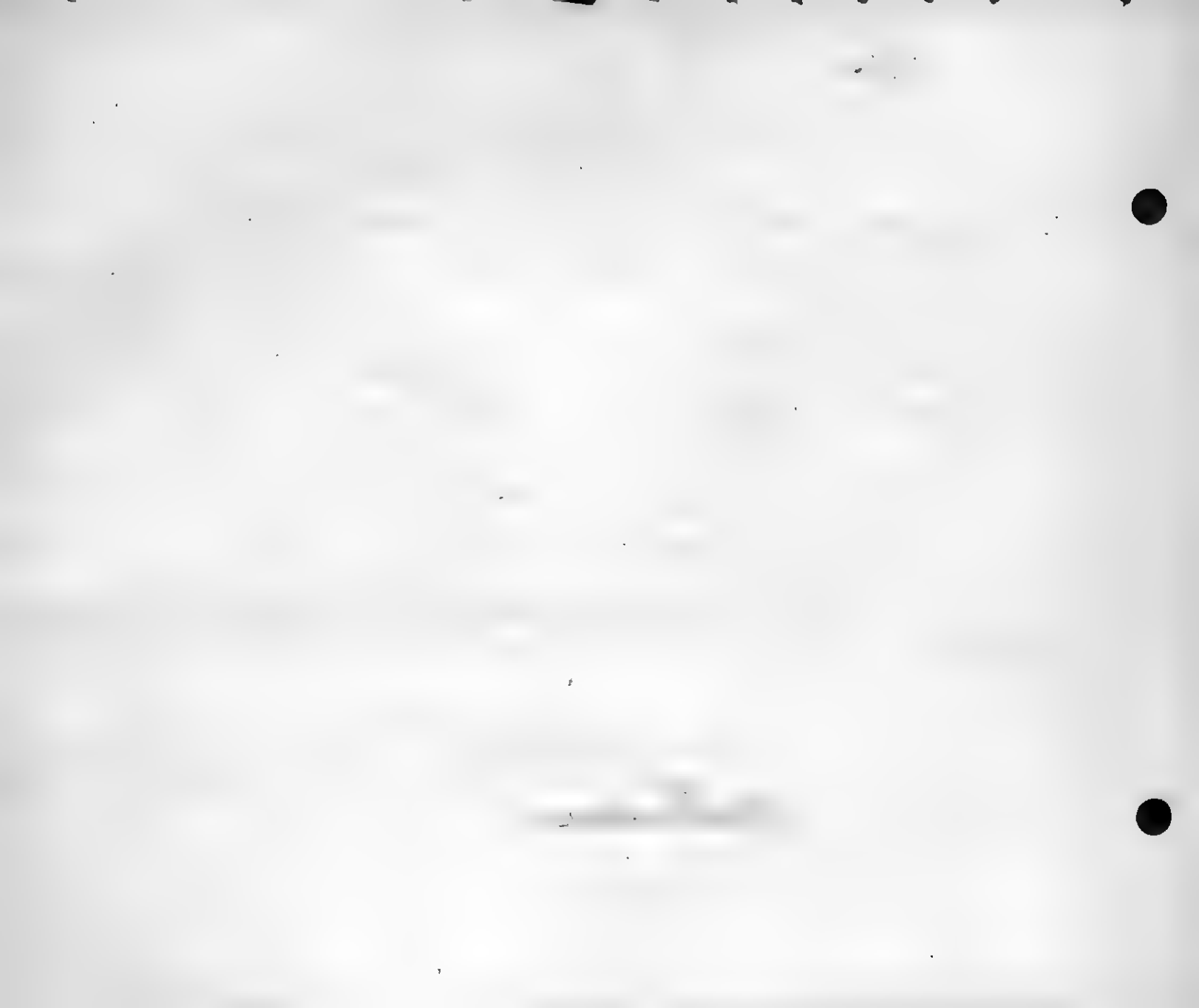
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 10643 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore, Md</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY _____ | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | | | | | c. LENGTH OF STAY IN <u>1 1/2 yrs</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stella Maris Hospice</u> | | | | | | d. STREET ADDRESS <u>4301 Roland Ave.,</u> | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Rosa R</u> Middle <u>Jessa</u> Last <u>8/6/07</u> | | | | | | 4. DATE OF DEATH <u>8/6/07</u> 19 <u>19</u> | | | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>2/9/1873</u> | | 9. AGE (In years last birthday) <u>94</u> yrs. | | 10. IF UNDER 1 YEAR Months _____ Days _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u> | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (County & State, or foreign country) <u>Bavaria</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | | | | | |
| 13. FATHER'S NAME <u>Franz Joseph Ruff</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Maria Augusta Reinhard</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) | | | | | | 16. SOCIAL SECURITY NO. <u>217-118-2516</u> | | 17. INFORMANT <u>Hospice records</u> | | Address _____ | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1. Infarct Cerebral</u> | | | | | | | | | | | |
| DUE TO (b) <u>2. Pulmonary Ca. Colon</u> | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>3. Scurvy</u> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | | 20f. (City or town) _____ (County) _____ (State) _____ | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/28/06</u> , 19 <u>19</u> , to <u>8/6/07</u> , 19 <u>19</u> , that (I) (we) last saw the deceased alive on <u>8/1/07</u> , 19 <u>19</u> , and that death occurred at <u>8:55A</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Robert Mahon</u> M.D. | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>8/6/07</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Robert Mahon, M.D.</u> | | | | | | 22d. ADDRESS <u>204 E. Joppa Rd., Towson</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>8-10-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem.</u> | | 23d. LOCATION (City, town or county) <u>Anne Arundel Md.</u> | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>C.F. EVANS & SON 8802 Harford road</u> | | | | | | 25a. REC'D BY REGISTRAR <u>AUG 9 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore Co. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1207 Nolan Court Balto., Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) (New Born Baby) Vanessa Jones 5. SEX Female 6. COLOR OR RACE C 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 7/31/67 9. AGE (in years last birthday) 0 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - 10b. KIND OF BUSINESS OR INDUSTRY - 11. BIRTHPLACE (County & State, or foreign country) Baltimore Co., Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | 4. DATE OF DEATH Month 8 Day 1 Year 19 67 13. FATHER'S NAME Kelvin NMN Hankerson 14. MOTHER'S MAIDEN NAME Carolyn Jones 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) - 16. SOCIAL SECURITY NO. - 17. INFORMANT Mother's Chart Address Same | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory distress DUE TO Aspiration pneumonia CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) - DUE TO (c) - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - INTERVAL BETWEEN ONSET AND DEATH 29 hrs. 51 m. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) - 20c. TIME OF INJURY Month, Day, Year 19 67 Hour a.m. 10:10 p.m. - 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - 20f. (City or town) (County) (State) - | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/31, 19 67, to 8/1, 19 67, that (I) (we) last saw the deceased alive on 8/1, 19 67, and that death occurred at 10:10, from the causes and on the date stated above. 22a. SIGNATURE <i>R. Breiteneker</i> a.m. 22c. PHYSICIAN'S NAME (Type) R. Breiteneker, M.D. 22d. ADDRESS 6701 N. Charles Street 22b. DATE SIGNED 8/1/67 22e. REC'D BY REGISTRAR Wm.C. March 22f. REGISTRAR'S SIGNATURE <i>Charles Judge</i> 22g. DATE AUG 7 1967 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 8/4/67 23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem. 23d. LOCATION (City, town or county) (State) Anne Arundel Cty. Md. | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

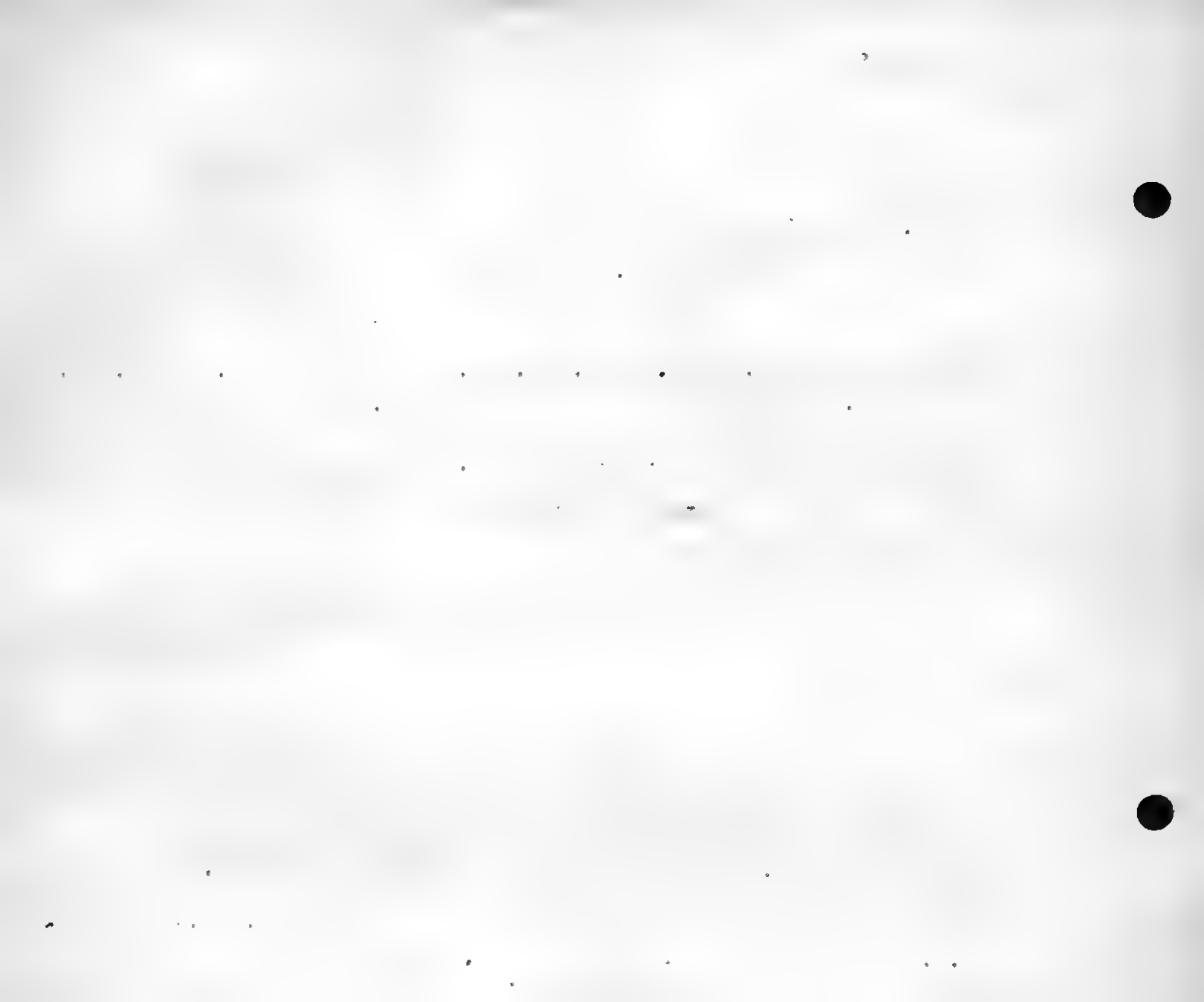
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10645

CERTIFICATE OF DEATH

10645

| | | | | | |
|--|---|--|---|--|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital | | | d. STREET ADDRESS 5712 Leith Walk | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3 NAME OF DECEASED (Type or print) First Middle Last Earl C. Jordan | | | 4. DATE OF DEATH Month Day Year August 8 19 67 | | |
| 5 SEX M | 6 COLOR OR RACE W | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH August 1, 1906 61 yrs | | 9 AGE (In years last birthday) Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor St. of Md. Dept. Emp. Sec. | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md. | |
| 13. FATHER'S NAME George T. Jordan | | | 14. MOTHER'S MAIDEN NAME Sadie B. Geyer | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII | | 16. SOCIAL SECURITY NO. 213-01-5394 | | 17. INFORMANT Address Mrs. Jo Ann Jordan (Same) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Myocardial Infarction DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 8/1/67 19____, and that death occurred at 6p M, from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE John Russell Davis | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Russell Davis | | 22d. ADDRESS Medical Arts Bldg. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/12/1967 | 23c. NAME OF CEMETERY OR CREMATORY Oaklawn | | 23d. LOCATION (City or Town) (County) (State) Balto. Co., Md. | |
| 24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | 25a. REC'D BY REGISTRAR DATE AUG 11 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10646

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10646

Item # 1-1111 # 1-9/ 9/22/67 pb

| | | | |
|--|------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Plant Dispensary | | d. STREET ADDRESS 4536 Shamrock Ave #6 | |
| 3. NAME OF DECEASED (Type or print) Edwin Edmund Raymond Kantorski | | 4. DATE OF DEATH Month 8 Day 2 Year 1967 | |
| 5. SEX Male | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/22/14 |
| 9. AGE (In years last birthday) 53 yrs. | | IF UNDER 1 YEAR Months 8 Days 2 Hours 19 Min. | IF UNDER 24 HRS. Hours 19 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman (Railroad) | | 10b. KIND OF BUSINESS OR INDUSTRY Steel Makin | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME John Kantorski | | 14. MOTHER'S MAIDEN NAME unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) | | 16. SOCIAL SECURITY NO. 216-01-9747 | |
| 17. INFORMANT Alvina Wolf Kantorski, wife, above | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4-- DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) N | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE M. B. Davis | | 22. DATE SIGNED 8-2-67 | |
| EXAMINER'S NAME (Type) M. B. Davis, M.D. 6800 Morningside Rd. Dundalk, Md. 21222 | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/7/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | | 23d. LOCATION (City, town or county) (State) Baltimore, Md. | |
| 24. FUNERAL DIRECTOR Schimmek Funeral Home, Inc. | | 25a. REC'D BY REGISTRAR Charles Judge | |
| ADDRESS 3331 Brehms Lane | | DATE AUG 4 1967 | |

10647

CERTIFICATE OF DEATH

10647

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | d. STREET ADDRESS 1919 Armco Way #21222 | |
| 3. NAME OF DECEASED (Type or print) Caroline J. Keller | | 4. DATE OF DEATH Month August Day 8 Year 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 30, 1915 |
| 9. AGE (In years last birthday) 51 yrs | | 10. IF UNDER 1 YEAR Months 8 Days 19 Hours 67 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Packer | | 10b. KIND OF BUSINESS OR INDUSTRY Albert F. Goetzke & Co. | |
| 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Anton Runge | | 14. MOTHER'S MAIDEN NAME Anna Janda | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO 215-01-0461 | |
| 17. INFORMANT Albert C. Keller, husband, above | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 1992 IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour: a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from August 7, 1967 , to August 8, 1967 , that (I) (we) last saw the deceased alive on August 8, 1967 , and that death occurred at 1:10AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Jaime Ambrad</i> | | 22b. DATE SIGNED August 8, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Jaime Ambrad, M.D. | | 22d. ADDRESS 7620 York Road #21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/11/67 | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery | 23d. LOCATION (City or Town) (County) (State) Balto., Md. |
| 24. FUNERAL DIRECTOR Schimunek Funeral Home 3331 Brehms Lane #13 | | 25a. REC'D BY REGISTRAR DATE AUG 11 1967 | |
| 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10648
CERTIFICATE OF DEATH
10648

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE MD. b. COUNTY BALTIMORE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | | | c. LENGTH OF STAY IN 1b 5 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Frank Middle MICHAEL Last Keller | | | | 4. DATE OF DEATH Month 8/ Day 19 Year 19 67 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Cau | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH MAY 1 1884 | |
| 9. AGE (In years last birthday) 83 yrs. | | IF UNDER 1 YEAR Months 8 Days 19 Hours 19 Min. 67 | | 9. AGE (In years last birthday) 83 yrs. | | 10. IF UNDER 24 HRS. Months 8 Days 19 Hours 19 Min. 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED VET | | | | 10b. KIND OF BUSINESS OR INDUSTRY VETERINARY | | | |
| 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME FREDERICK KEWLER | | | | 14. MOTHER'S MAIDEN NAME GEORGIA DIETZ | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W.I. | | | | 16. SOCIAL SECURITY NO. 213-40-0057 | | | |
| 17. INFORMANT Patient's Chart | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4321 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Bronchopneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 8/14 , 19 67 , to 8/19 , 19 67 , that (I) (we) last saw the deceased alive on 8/19 , 19 67 , and that death occurred at 8:30 M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE John E. Adams | | | | 22b. DATE SIGNED 8/19/67 | | | |
| 22c. PHYSICIAN'S NAME (Type) John E. Adams, M.D. | | | | 22d. ADDRESS 6701 N. Charles Street | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE THEREOF | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Frank H. Newell, Pikesville, Md. | | | | 23d. LOCATION (City, town or county) (State) Pikesville, Md. | | | |
| 24. FUNERAL DIRECTOR Frank H. Newell, Pikesville, Md. | | | | 25. REC'D BY REGISTRAR Charles Judge | | | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | 25c. DATE AUG 24 1967 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10649

CERTIFICATE OF DEATH

10649

| | | | |
|---|--|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>BMC.</u> <u>BALTO.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WILSON</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> | |
| c. LENGTH OF STAY IN IB <u>8 DAYS</u> | | d. STREET ADDRESS <u>556 WEST University Ave.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. Medical Center</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) <u>Bertha</u> First <u>Virginia</u> Middle <u>Kelley</u> Last | | 4 DATE OF DEATH Month <u>8</u> Day <u>15</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Cauc.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOW <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-19-07</u> 9. AGE (In years last birthday) <u>60</u> yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of Education</u> | |
| 11 BIRTHPLACE (County & State, or foreign country) <u>Baltimore, MD.</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13 FATHER'S NAME <u>JOHN FRANCIS KELLEY</u> | | 14. MOTHER'S MAIDEN NAME <u>Josephine MORGAN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>213-10-9382</u> | |
| 17. INFORMANT <u>Admission SHEET</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral failure,</u> DUE TO (b) <u>Carcinoma Colon & metastatic disease.</u> DUE TO (c) <u>1921</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21 I certify that (I) (this hospital) attended the deceased from <u>8 July, 1967</u> , to <u>15 July, 1967</u> , that (I) (we) last saw the deceased alive on <u>14 July 1967</u> , and that death occurred at <u>6:15 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Duncan McGhie</u> M.D. | | 22b. DATE SIGNED <u>15 Aug 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>DUNCAN MCGHIE</u> | | 22d. ADDRESS <u>5645 LOTUIAN Rd.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>8-18-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery Woodlawn Balto., Md.</u> | 23d. LOCATION (City or town) (County) (State) |
| 24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u> ADDRESS <u>21212 4905 York Rd. Balto., Md.</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE <u>AUG 16 1967</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|---|---|---|---|
| 10650 | | 10650 | |
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN ID <u>38 days</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3440 Chestnut Avenue</u> d. STREET ADDRESS <u>3440 Chestnut Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>CARMEN BLANCHE KELL</u> First Middle Last | | 4. DATE OF DEATH <u>8/18/67</u> Month Day Year | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>CAU</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/17/94</u> 9. AGE (In years last birthday) <u>73</u> If UNDER 1 YEAR: Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | |
| 11. BIRTHPLACE (County & State) <u>W. INDIES-T. SLEOF-ST. KIT</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | |
| 13. FATHER'S NAME <u>PERCY TODD</u> | | 14. MOTHER'S MAIDEN NAME <u>LAURA PEDDER</u> | |
| 15. WAS DECEASED EVER IN ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>069-07-8196</u> | |
| 17. INFORMANT <u>PATIENT CHART</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of inferior vena cava</u> DUE TO (b) <u>Chronic renal disease</u> DUE TO (c) <u>Chronic ophea 70 years, Mild emphysema</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1020, conv</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/12</u> , 19 <u>67</u> , to <u>8/18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/18</u> , 19 <u>67</u> , and that death occurred at <u>840M</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Deveh A Bruce</u> | | 22b. DATE SIGNED <u>8/18/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>DEVEH A. BRUCE</u> | | 22d. ADDRESS <u>B. H. C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>8-21-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park Cemetery</u> | 23d. LOCATION (City, town or county) (State) <u>Baltimore Co., Md.</u> |
| 24. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u> ADDRESS <u>4905 York Road Balto., Md.</u> | | 25a. REC'D BY REGISTRAR <u>AUG 21 1967</u> DATE | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

141

3
The action of the
court was to

show that the

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10651

10651

| | | | |
|---|---|--|--|
| 1 PLACE OF DEATH a COUNTY BALTO MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MD. b. COUNTY BALTO | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX - 21 | | c LENGTH OF STAY IN 1b ESSEX - | |
| d NAME OF HOSPITAL, DR INSTITUTION (If not in hospital, give street address) ROCKAWAY BEACH | | d STREET ADDRESS 605 N. STUART | |
| 3 NAME OF DECEASED (Type or print) THERESA KELLY | | 4 DATE OF DEATH 8 Month 20 Day 19 Year 67 | |
| 5 SEX F | 6 COLOR OR RACE W | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 4/18/59 |
| 9 AGE (in years last birthday) 8 yrs | | F UNDER 1 YEAR <input type="checkbox"/> F UNDER 24 HRS <input type="checkbox"/> Months Days Hours Min. | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (State or foreign country) MD. | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME THOMAS KELLY SR. | | 14 MOTHER'S MAIDEN NAME SALLY NOCKMAN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO — | |
| 17 INFORMANT THOMAS KELLY | | Address ABOVE | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 8 DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part of item 1b) Slipped and while in picnic | |
| 20c. TIME OF INJURY Month Day Year 13 Hour pm 8-19-67 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) middle town | 20f. (City or town) (County) (State) Essex-21 Balto Md |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE M.B. Davis | | 22. DATE SIGNED 8/23/67 | |
| EXAMINER'S NAME (Type) M.B. DAVIS M.D. | | Address 6000 McKim Ave - Suite 101 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 8/23/67 | 23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL | 23d. LOCATION (City or town) (County) (State) BALTO. MD. |
| 24 FUNERAL DIRECTOR J.S. CONNELLY SONS | | 25a. REC'D BY REGISTRAR 300 MACE | |
| 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | DATE AUG 25 1967 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10652

CERTIFICATE OF DEATH

10652

| | | | | | |
|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown | | c. LENGTH OF STAY IN 1b 19 yrs | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 244 Liberty Road | | | d. STREET ADDRESS Box 244 Liberty Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Thomas Kettlewell | | | 4. DATE OF DEATH Month August Day 31 Year 1967 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 17, 1892 | | 9. AGE (in years) 75 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Revere Copper & Brass Maryland | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME Charles Kettlewell | | |
| 14. MOTHER'S MAIDEN NAME PYFER CORA Pfeifer | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | |
| 16. SOCIAL SECURITY NO 216-10-9875 | | | 17. INFORMANT Mrs. Eulalia Kettlewell | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4. CARDIAC FAILURE DUE TO (b) CORONARY OCCLUSION DUE TO (c) arteriosclerosis (ASCVD) | | | INTERVAL BETWEEN ONSET AND DEATH 20 hrs. | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21. I certify that (I) (this hospital) attended the deceased from 1953 to AUG-31, 1967 , that (I) (we) last saw the deceased alive on 8-31, 1967 , and that death occurred at 3:50 AM , from causes and on the date stated above | | | | | |
| 22a. SIGNATURE R. V. Houck Jr. | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED 9/1/67 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. R. V. Houck Jr. | | 22d. ADDRESS Liberty Rd. Eldersburg, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 9/2/67 | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park | 23d. LOCATION (City or Town) (County) (State) 3801 Frederick Rd. Balto. Md. | | |
| 24. FUNERAL DIRECTOR Spring Myers 8728 Liberty Rd. Randallstown | | 25a. REC'D BY REGISTRAR SEP 5 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Jones | |

MEDICAL CERTIFICATION

10653

CERTIFICATE OF DEATH

10653

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN 1b 56 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | e. STREET ADDRESS 3728 PARK HEIGHTS AVENUE f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First JAMES Middle JOSEPH Last KIGGINS, JR. | | 4. DATE OF DEATH Month AUGUST Day 10 Year 67 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/7/07 |
| 9. AGE (In years last birthday) 59 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK | | 10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE CITY | |
| 11. BIRTHPLACE (County & State, or foreign country) PHILADELPHIA, PA. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JAMES KIGGINS | | 14. MOTHER'S MAIDEN NAME unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II | | 16. SOCIAL SECURITY NO 226 03 06 58 | |
| 17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 500A IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO (b) HYPERTENSION DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS 10 YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CHRONIC BRONCHITIS | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6/15/67 , 19__ to 8/10/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/10/67 , 19__, and that death occurred at 4:05 PM on causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Jorge A. Fabara</i> | | 22b. DATE SIGNED 8/10/67 | |
| 22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M. D. | | 22d. ADDRESS VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 8/14/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR Leonard J. RUCK FUNERAL HOME ADDRESS HARFORD ROAD, BALTIMORE, MD. | | 25a. REC'D BY REGISTRAR AUG 11 1967 | |
| 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10654

10654

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

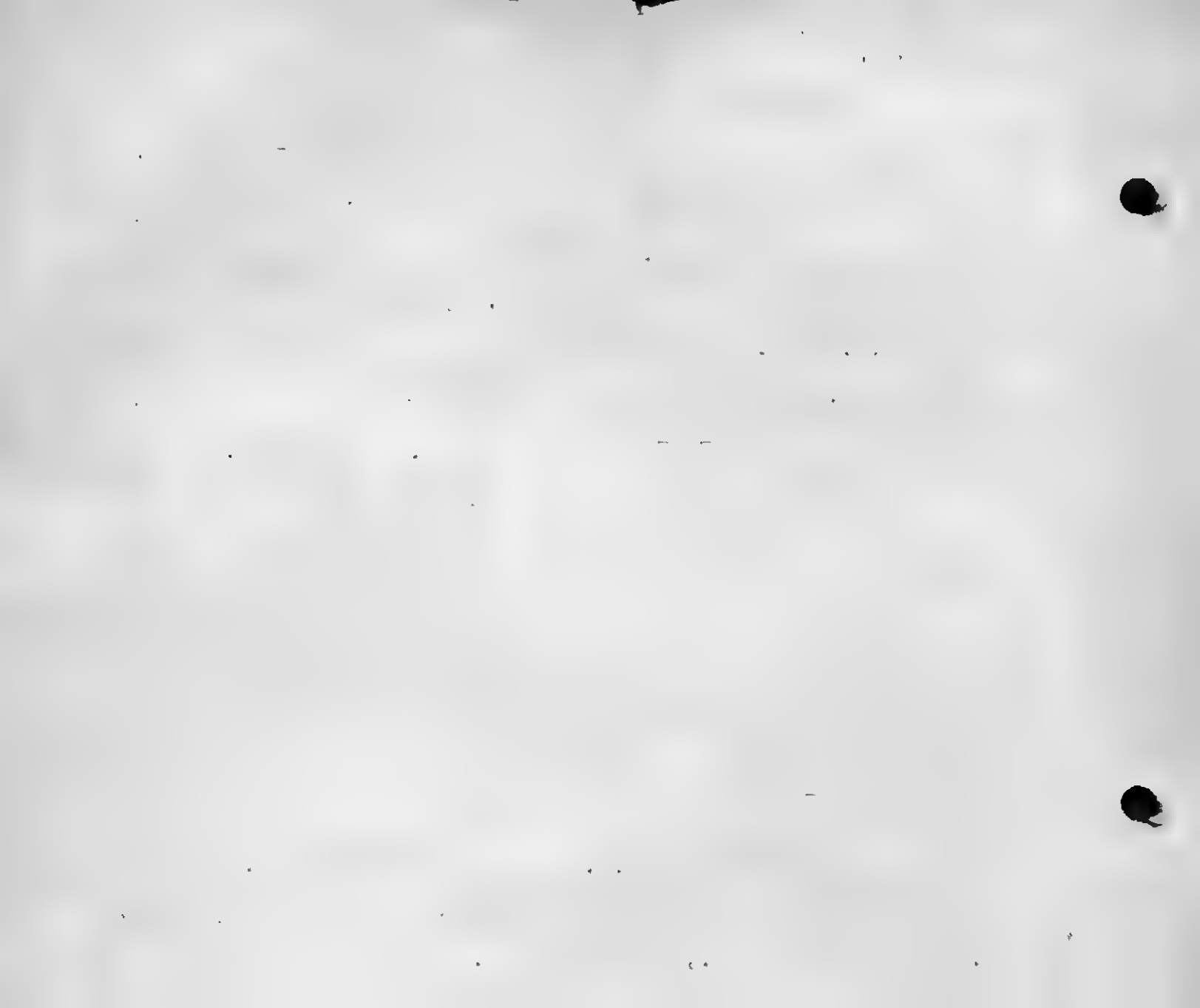
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|---|--|
| 1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY - RURAL | | c. LENGTH OF STAY in 1b RURAL - ELLICOTT CITY | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ROUTE 4 | | d. STREET ADDRESS ROUTE 4 | |
| 3 NAME OF DECEASED (Type or print) Eva King | | 4 DATE OF DEATH Month 8 Day 24 Year 1967 | |
| 5 SEX F | 6 COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 10/8/1890 1899 |
| 9 AGE (in years last birthday) 77 yrs | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| 10b. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11 BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | |
| 12 CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME JOHN H. PARRISH | |
| 14. MOTHER'S MAIDEN NAME REBECCA METCALF | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | |
| 16. SOCIAL SECURITY NO. ? | | 17. INFORMANT GLORIA BELL Address 7 WINTERS LANE BALTIMORE 28, MARYLAND | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular disease 4221 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH Sudden |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) _____ | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE James N. Frederick M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) James N. Frederick MD | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 1311 Francis Ave Address (Street, city, town, or county) Baltimore | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 8/28/67 | 23c. NAME OF CEMETERY OR CREMATORY LAKE VIEW | 23d. LOCATION (City or Town) (County) (State) ELDERSBURG, CARROLL, MD. |
| 24. FUNERAL DIRECTOR John R. Slack Higginbotham-Slack Funeral Home | | 25a. REC'D BY REG. STRAR 106 Columbia Rd. Ellicott City, MD. AUG 28 1967 | 25b. REG. STRAR'S SIGNATURE John R. Slack |

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10655 CERTIFICATE OF DEATH 10656

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN b. MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Towson Convalescent Home | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore - 21214 d. STREET ADDRESS 1529 E. Coldspring Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) EDWARD C. KNOX | | 4. DATE OF DEATH August 28, 1967 | |
| 5. SEX Male | | 6. COLOR OR RACE White | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH Jan. 6, 1888 | |
| 9. AGE (In years last birthday) 79 yrs. | | 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) guard-U.S.Gov't. | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 11. BIRTHPLACE (County & State or foreign country) Canada | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Edward F. Knox | | 14. MOTHER'S MAIDEN NAME unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 220-01-6213 | |
| 17. INFORMANT Mrs Mary V. Knox | | Address 1529 E. Coldspring Lane | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma Prostate DUE TO Metastases to lungs & liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 14yr DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH 14yr | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Aug 26, 1967 to Aug 28, 1967 , that (I) (we) last saw the deceased alive on 8/28/67 , and that death occurred at 7:20 PM , from the causes and on the date stated above | | 22a. SIGNATURE Laurence Post | |
| 22c. PHYSICIAN'S NAME (Type) Laurence Post, M.D. | | 22b. DATE SIGNED Aug 28, 1967 | |
| 22d. ADDRESS 6805 York Rd. Baltimore | | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE THEREOF 8/31/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery | | 23d. LOCATION (City, town or county) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE H. Sander & Sons, Inc., Baltimore, Md. | | 25a. REC'D BY REGISTRAR AUG 31 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



10656

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10657

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|---|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5900 Southwestern Blvd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) WILLIAM IRVIN KOCH | | 4 DATE OF DEATH Month August Day 6 Year 1967 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 11/2/95 |
| 9 AGE (In years last birthday) 71 yrs | | 10a USUAL OCCUPATION (Give kind of work done during most of life, even if retired) Retired | |
| 10b. KIND OF BUSINESS OR INDUSTRY Pumper | | 11 BIRTHPLACE (State or foreign country) Maryland | |
| 12 CITIZEN OF WHAT COUNTRY? USA | | 13 FATHER'S NAME Koch | |
| 14 MOTHER'S MAIDEN NAME Unknown | | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 7/25/47-7/5/48 | |
| 16 SOCIAL SECURITY NO. 215-12-8463A | | 17 INFORMANT Address Mrs. Nora A. Koch, 1458 Battery Ave. 21230 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 4221 | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>Russell S. Fisher</i> EXAMINER'S NAME (Type) Russell S. Fisher, M.D. | | 22. DATE SIGNED August 7, 1967 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE THEREOF 8/10/67 | |
| 23c NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore Md. | | 23d LOCATION (City or Town) (County) (State) | |
| 24 FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | 25a REC'D BY REGISTRAR DATE AUG 14 1967 | |
| | | 25b REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10657

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10658

| | | | |
|--|--------------------------|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore County MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE b. COUNTY Virginia Fairfax | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN 1b 3 months | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church | | d. STREET ADDRESS 2212 N. Trinidad Street | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sheppard- Enoch Pratt Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Delores Evaleen KOENIG | | 4 DATE OF DEATH Month Day Year August 19 1967 | |
| 5 SEX female | 6 COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 3/24/37 |
| 9 AGE (In years birthdate) 34 yrs | | 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| 10b KIND OF BUSINESS OR INDUSTRY - | | 11 BIRTHPLACE (State or foreign country) West Virginia | |
| 12 CITIZEN OF WHAT COUNTRY? U.S.A. | | 13 FATHER'S NAME Paul Victor Eby | |
| 14 MOTHER'S MAIDEN NAME Annabelle Johnson | | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no - - - | |
| 16 SOCIAL SECURITY NO. 264-52-0526 | | 17 INFORMANT Hospital records | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH Sudden |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia Compensated Type Hanging Seen Close by Best | | | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) | |
| 20c TIME OF INJURY Month Day Year 8/19/67 | | 20d PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.) Hospital - Mental Illness | |
| 20e (City or town) Arlington, Va. | | 20f (County) Arlington | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles F. O'Donnell, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b DATE THEREOF 8-24-1967 | |
| 23c NAME OF CEMETERY OR CREMATORY Columbia Gardens Cem. | | 23d LOCATION (City or town) (County) (State) Arlington, Va. | |
| 24 FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. | | 25a KEPT BY REGISTRAR AUG 24 1967 | |
| 25b REGISTRAR'S SIGNATURE Charles Judge | | 22 DATE SIGNED 8/19/67 | |

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

10658

10659

1. PLACE OF DEATH
e. COUNTY

Balto

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural Balto

c. LENGTH OF STAY IN 1b

10 mo

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

St Joseph Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

a. STATE Md.

b. COUNTY

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Baltimore

d. STREET ADDRESS

515 S. Glower St

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

ANNA

First

Middle

Last

DATE OF DEATH

Month

Day

Year

Kozubski

AUG

16

1967

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

1880

OCT

16

86

yr.

9. AGE (in years last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10b. KIND OF BUSINESS OR INDUSTRY

home

11. BIRTHPLACE (County & State, or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Stanley Choma

14. MOTHER'S MAIDEN NAME

Kozak

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

chant

Address

8614 OAK RD

WANDA PANIOWICZ

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)

Heart failure

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

INTERVAL BETWEEN ONSET AND DEATH

1 mo

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (th's hospital) attended the deceased from June 15, 1967 to 15 Aug 1967, that (I) (we) last saw the deceased alive on 15 Aug 1967, and that death occurred at 12:45 from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

WILLIAM GOODMAN

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

16 Aug 67

22d. ADDRESS

133 S. SULLY SPRING RD 4227

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

8-17-67

23c. NAME OF CEMETERY OR CREMATORY

HOPE ROSARY CEMETERY

23d. LOCATION (City, town or county)

DUNDY

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Edward J. Nefer

ADDRESS

JOHN W. WILDER SON INC FUNERAL HOME

25a. REC'D BY REGISTRAR

AUG 18 1967

25b. REGISTRAR'S SIGNATURE

William J. Judge

401 S CHESTER ST

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

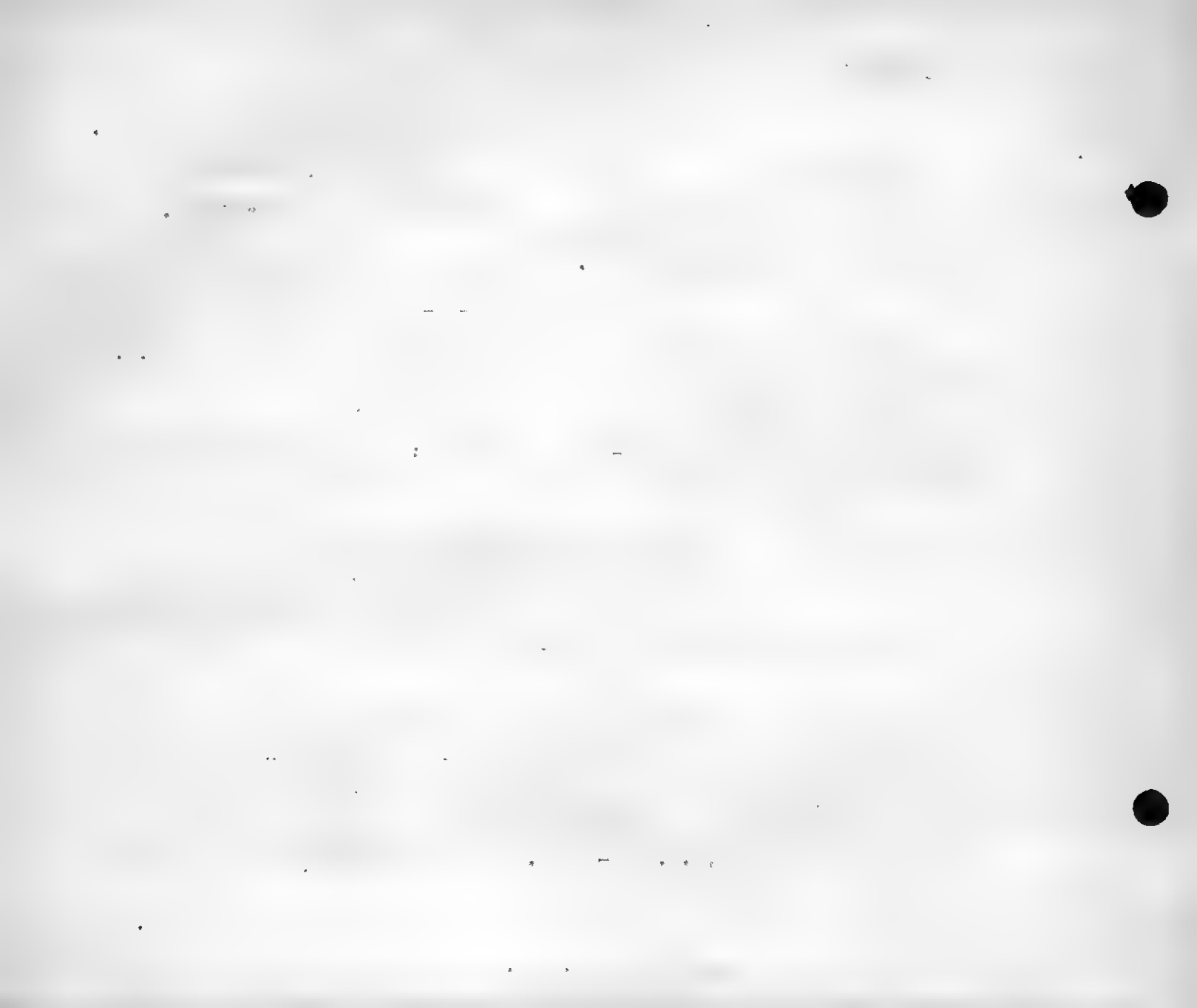
10659

CERTIFICATE OF DEATH

10660

| | | | |
|--|-------------------------------|---|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN TB 2 YEARS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital | | e. STREET ADDRESS 2809 Silver Hill Road Ave. | |
| 3. NAME OF DECEASED (Type or print) First Jerome Middle J. Last Krein | | 4. DATE OF DEATH Month 8 Day 6 Year 67 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12-29-83 |
| 9. AGE (in years last birthday) 83 yrs | | IF UNDER 1 YEAR: Months 6 Days 19 IF UNDER 24 HRS: Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY DEPT. STORES | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Frank | | 14. MOTHER'S MAIDEN NAME Annie HUBER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown | | 16. SOCIAL SECURITY NO 215-03-2551 | |
| 17. INFORMANT Records: Spring Grove State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Heart Failure | | | |
| DUE TO (b) Arteriosclerotic Heart Disease | | | |
| DUE TO (c) Generalized Arteriosclerosis, severe | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Several decubital ulcers (buttocks, both heels) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) none | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. none p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10-22 , 19 65 , to 8-6 , 19 67 , that (I) (we) last saw the deceased alive on August 6 , 19 67 , and that death occurred on 2-30 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Imre Kopits | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Imre KOPITS, M.D. (K-7077) | | 22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/ 9/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery Woodlawn, Md. | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR Raymond C. Fink Glen Burnie, Md. 21061 | | 25a. REC'D BY REGISTRAR AUG 8 1967 | |
| 25b. REGISTRAR'S SIGNATURE J. J. Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10660

CERTIFICATE OF DEATH

10661

| | | | | | | | |
|--|--|--|--|---|--|---|---|
| 1 PLACE OF DEATH a. COUNTY TOWSON - BALTIMORE MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE-TOWSON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL TOWSON | | c. LENGTH OF STAY IN 1b 34 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON - HAMPTON | | d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER | | | | d. STREET ADDRESS 1300 WOODSHOLE ROAD | | | |
| 3 NAME OF DECEASED (Type or print) First Middle Last MILFORD FISKE LACKEY | | | | 4. DATE OF DEATH Month Day Year AUGUST 5 1967 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE CAU | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6/26/1904 | |
| 9. AGE (In years last birthday) 63 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PERSONNEL OFFICER ST. OF Md. HYGIENE | | 10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE MARYLAND | | 11. BIRTHPLACE (County & State or foreign country) U.S.A. | |
| 13. FATHER'S NAME OSCAR FRANCIS LACKEY | | | | 14. MOTHER'S MAIDEN NAME MARYMYER | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 215-03-9443 | | 17. INFORMANT Address MRS. SUSANNA M. LACKEY (SAME) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure DUE TO (b) Cerebro-vascular accident. DUE TO (c) arteriosclerotic & hypertensive heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/3 , 19 67 , to 8/5 , 19 67 , that (I) (we) last saw the deceased alive on 8/5 , 19 67 , and that death occurred at 8:23 AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Derth A. Bruce | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 8/5/67 | |
| 22c. PHYSICIAN'S NAME (Type) Derth A. Bruce, M. D. | | | | 22d. ADDRESS Greater Balto. Medical Center | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/9/1967 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | | 25a. REC'D BY REGISTRAR AUG 7 1967 | | 25b. REGISTRAR'S SIGNATURE John L. Judge | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10661

CERTIFICATE OF DEATH

10662

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.


TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 10 hours after death.

| | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|
| 1 PLACE OF DEATH a COUNTY Baltimore | | b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c LENGTH OF STAY IN 1b 21087 | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland | | b COUNTY 1 | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital | | | | d STREET ADDRESS Rt. 1, Box 347 - Chapman Rd. | | | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) John Alfred LAHOURATATE | | 4 DATE OF DEATH Month 8 Day 27 Year 1967 | | 5 SEX Male | | 6 COLOR OR RACE White | | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH 6-24-1891 | |
| 8 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 AGE (In years last birthday) 76 yrs | | 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (County & State, or foreign country) France | |
| 12. CITIZEN OF WHAT COUNTRY? France | | 13. FATHER'S NAME Basil Lahouratate | | 14. MOTHER'S MAIDEN NAME Catherine Bernadou | | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16 SOCIAL SECURITY NO 218-32-5449 | |
| 17. INFORMANT Mrs Marie Rawl Chapman Raod Kingsville, Md. | | 18. ADDRESS 21087 | | 19. WAS ALTPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) advanced emphysema DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Malnutrition. | | 19. WAS ALTPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | |
| 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 21. I certify that 1 (this hospital) attended the deceased from August 25, 1967 , to August 27, 1967 , that 1 (we) last saw the deceased alive on August 27, 1967 , and that death occurred at 6:30 AM , from causes and on the date stated above. | | 22a SIGNATURE Reynaldo Orjuela-Gomez, M.D. | |
| 22b. DATE SIGNED August 27, 1967 | | 22c PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D. | | 22d ADDRESS 7620 York Rd., Towson, Md. 21204 | | 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8-30-1967 | |
| 23c NAME OF CEMETERY OR CREMATORY St. Stephens Cemetery | | 23d LOCATION (City or Town) (County) (State) Brookshaw, Balto. Md. | | 24. FUNERAL DIRECTOR Lassahn Funeral Home 4401 Belair Rd | | 25a REC'D BY REGISTRAR AUG 30 1967 | | 25b REGISTRAR'S SIGNATURE J. Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|----------------------------------|--|---|---|--|--|---|--|---|--|-------------------------------|--|--|---|--|--|--|--|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | | | | | | |
| 10662 | | | | | CERTIFICATE OF DEATH | | | | | 10663 | | | | | | | | | | | | | | |
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | | 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Delaware b. COUNTY Sussex | | | | | | | | | | | | | | | | | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | | | | c LENGTH OF STAY IN TB | | | | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millford | | | | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital | | | | | d STREET ADDRESS 204 Lovers Lane | | | | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 3 NAME OF DECEASED (Type or print) John Joseph Lancaster | | | | | 4 DATE OF DEATH Month August Day 17 Year 1967 | | | | | | | | | | | | | | | | | | | |
| 5 SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH October 3, 1901 | | 9 AGE (In years last birthday) 65 yrs | | 10 UNDER 1 YEAR Months Days Hours Min. | | 11 UNDER 24 HRS Hours Min. | | | | | | | | | | | | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired | | | | | 10b KIND OF BUSINESS OR INDUSTRY Auto Sales & Service | | | | | 11 BIRTHPLACE (County & State, or foreign country) Media, Pennsylvania | | | | | 12 CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | |
| 13. FATHER'S NAME Thomas Robert Lancaster | | | | | 14. MOTHER'S MAIDEN NAME Sara Elizabeth Evans | | | | | | | | | | | | | | | | | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | | | | 16. SOCIAL SECURITY NO 216 09 3962 | | | | | 17 INFORMANT Mrs. Joseph Bremer, Baltimore, Md. | | | | | Address | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465X Cardio pulmonary Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Pulmonary Infarction, Multiple DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18) | | | | | | | | | | | | | | | | | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | | 20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | 20f (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from July 8th, 1967 , to August 17, 1967 , that (I) (we) last saw the deceased alive on August 17 19 67 , and that death occurred at 1:30 A.M. from causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a SIGNATURE  | | | | | | | | | | M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | | | 22b DATE SIGNED 8-17-67 | | | | | | | | | |
| 22c PHYSICIAN'S NAME (Type) Jaime Singzon, M.D. | | | | | | | | | | 22d ADDRESS 7620 York Rd., Towson 21204 | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | 23b DATE THEREOF 8/20/67 | | | | | 23c NAME OF CEMETERY OR CREMATORY Chester Cemetery | | | | | 23d LOCATION (City or Town) (County) (State) Chestertown, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR Wm A. Berry Jr Millard, Del. | | | | | | | | | | ADDRESS | | | | | 25a. REC'D BY REGISTRAR AUG 22 1967 | | | | | 25b. REGISTRAR'S SIGNATURE  | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

10666

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10664

| | | | |
|--|--|--|---|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 21204</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u> | | d. STREET ADDRESS <u>1201 Doves Cove Rd.</u> | |
| 3 NAME OF DECEASED (Type or print) <u>William Edward Lehr</u> | | 4. DATE OF DEATH Month <u>8</u> Day <u>4</u> Year <u>1967</u> | |
| 5 SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>9-20-97</u> 9. AGE (In years last birthday) <u>69</u> yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State or foreign country) <u>Balto., Md.</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Wm. Lehr</u> | | 14. MOTHER'S MAIDEN NAME <u>Catherine Ortman</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>WW I and II</u> | | 16 SOCIAL SECURITY NO <u>214-40-2665</u> | |
| 17 INFORMANT <u>patient's chart.</u> | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1571</u> DUE TO (b) <u>Liver Metastasis</u> DUE TO (c) <u>to Metastasis?</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8-24</u> , 19 <u>67</u> to <u>8-4</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8-4</u> , 19 <u>67</u> and that death occurred at <u>3:12 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Jose M. de Leon, M.D.</u> | | 22b. DATE SIGNED <u>8-4-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>JOSE M. DE LEON, M.D.</u> | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | 23b. DATE THEREOF <u>Aug. 5. 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematorium</u> | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u> |
| 24. FUNERAL DIRECTOR <u>HENRY SANDER & SONS, INC.</u> | | 25a. REC'D BY REGISTRAR <u>AUG 7 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

10664

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If city or day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN It St. Joseph Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore 21234 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 9850 Harford Rd. d. STREET ADDRESS 9850 Harford Rd. e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Annie Crawford Lisle First Middle Last | | | | 4. DATE OF DEATH August 16, 1967 Month Day Year | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH February 18, 1892 Age (In years lost birthday) 85 yrs | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME John D. Lisle | | | | 14. MOTHER'S MAIDEN NAME Annie Crawford | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-46-8109 | | 17. INFORMANT Mr. Robert D. Lisle Address Baltimore, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure Following DUE TO 16 Days (b) Chronic bronchitis DUE TO 16 Days (c) Fractured left Hip DUE TO 6 Wks Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell in own Home | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 1300 p.m. July 5, 1967 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home | | 20f. (City or town) (County) (State) Parkville Baltimore Md | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Charles F. O'Donnell EXAMINER'S NAME (Type) Charles f. O'Donnell, M.D. | | | | 22. DATE SIGNED 8/16/67 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town or county) | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Aug. 19, 67 | | 23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery | | 23d. LOCATION (City or town) (County) (State) Reisterstown, Md. | |
| 24. FUNERAL DIRECTOR J. F. Eline & Sons ADDRESS Reisterstown, Md. | | | | 25a. REC'D BY REGISTRAR AUG 18 1967 25b. REGISTRAR'S SIGNATURE Charles J. J. J. | | | |

10665

CERTIFICATE OF DEATH

10666

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|---|---|--|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | c. LENGTH OF STAY IN 1b <u>Baltimore</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Milford Manor Nursing Home</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>Liss</u> Last <u>Liss</u> | | 4 DATE OF DEATH <u>August 31</u> 19 <u>67</u> Month Day Year | |
| 5 SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>78</u> yrs |
| 10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | 11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u> |
| 13. FATHER'S NAME <u>Bank</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 17. INFORMANT Address <u>Mr. Gustave Liss, 6203 Lincoln Avenue #9</u> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis</u> 4201 DUE TO <u>myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>myocardial</u> (c) <u>infarction</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>yes</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1933</u> , 19 <u>67</u> to <u>8/29</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8/29</u> , 19 <u>67</u> and that death occurred at <u>10 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Milton Kirsh</u> M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. Milton Kirsh</u> | | 22d. ADDRESS <u>4000 W. Northern Parkway</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>9/1/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Har Zion Tifereth Israel</u> | 23d. LOCATION (City or Town) (County) (State) <u>Rosedale, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u> | | 25a. RECEIVED BY REGISTRAR <u>SEP 6 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Snodgrass</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10666

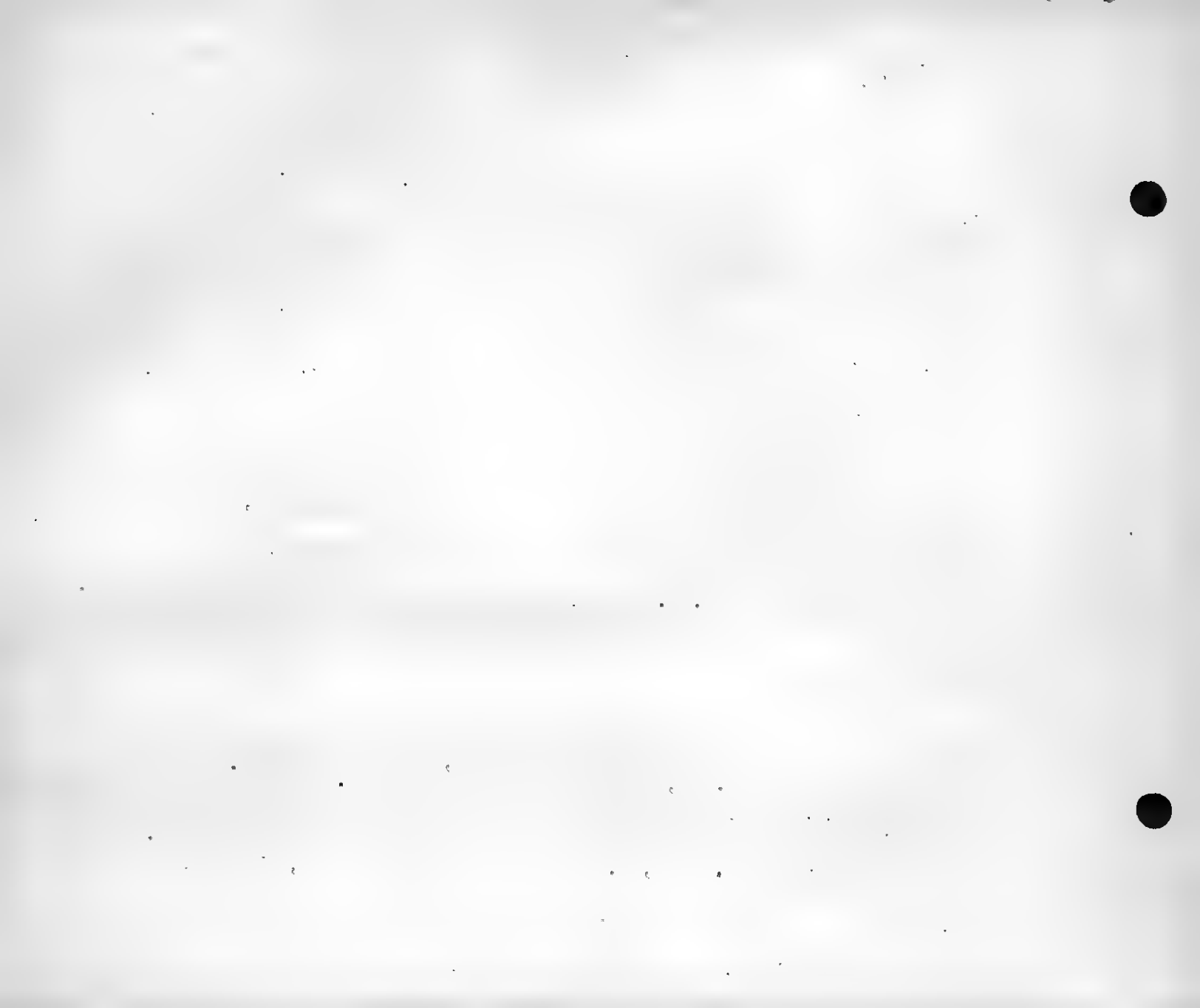
10667

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Rt. 26 Randallstown</u> | | | | c. LENGTH OF STAY IN 1b <u>3 Weeks</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randallstown - Chapel Hill Nursing Home</u> | | | | e. STREET ADDRESS <u>Bollinger Mill Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Louch</u> Last <u>Louch</u> | | | | 4. DATE OF DEATH Month <u>Aug.</u> Day <u>11</u> Year <u>1967</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>JAN. 21, 1885</u> | |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | 10. FUNERAL YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Chegoslavia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Chegoslavia</u> | |
| 13. FATHER'S NAME <u>Joseph Louch</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unk.</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u> </u> | | 17. INFORMANT <u>MRS. Caroline Louch - Finksburg, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach, Liver metastasis,</u> <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Lung metastasis, Bronchial pneumonia,</u> (c) <u>G. I. obstruction</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>May 5, 1967 through Aug. 11, 1967</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 5,</u> 19 <u>67</u> , to <u>Aug. 11, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug. 11,</u> 19 <u>67</u> , and that death occurred at <u>4P.</u> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Howard E. Hall</u> | | | | 22b. DATE SIGNED <u>Aug. 12, 1967</u> | | 22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u> | |
| 22d. ADDRESS <u>Sykesville, Maryland</u> | | | | 22e. ADDRESS <u>Sykesville, Maryland</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>8-14-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Westminster, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Harry W. Haight</u> | | | | 25a. REC'D BY REGISTRAR <u>AUG 16 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10667

10668

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN 16 18 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | e. STREET ADDRESS # 340 NEWKIRK STREET | |
| 3. NAME OF DECEASED (Type or print) First Middle Last NICHOLAS - LOULUDIS | | 4. DATE OF DEATH Month Day Year AUGUST 20, 1967 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/15/15 |
| 9. AGE (In years last birthday) 52 yrs | | 10. UNDER 1 YEAR Months Days Hours Min | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK | | 12. KIND OF BUSINESS OR INDUSTRY RESTAURANT | |
| 13. BIRTHPLACE (County & State, or foreign country) ANDROS, GREECE | | 14. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. EATHER'S NAME GEORGE LOULUDIS | | 16. MOTHER'S MAIDEN NAME SYLVIA POLETIS | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II | | 18. SOCIAL SECURITY NO. 072 05 86 06 | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) UREMIA DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) ARTERIOIAL NEPHROSCLEROSIS | | INTERVAL BETWEEN ONSET AND DEATH WEEKS YEARS YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (this hospital) attended the deceased from 8/2/67 , 19__, to 8/20/67 , 19__, that (we) last saw the deceased alive on 8/20/67 , 19__, and that death occurred at 11:15 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>John D. Talbert</i> | | 22b. DATE SIGNED 8/21/67 | |
| 22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D. | | 22d. ADDRESS VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 8/24/67 | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND | 23d. LOCATION (City or Town) (County) (State) |
| 24. FUNERAL DIRECTOR <i>Joseph N. Zannino</i> | | 25a. REC'D BY REGISTRAR AUG 25 1967 | |
| 25b. REGISTRAR'S SIGNATURE <i>James J. Zannino</i> | | 25c. ADDRESS ZANNINO FUNERAL HOME 257 S. CONKLING ST. BALTIMORE, MD. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please replace carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

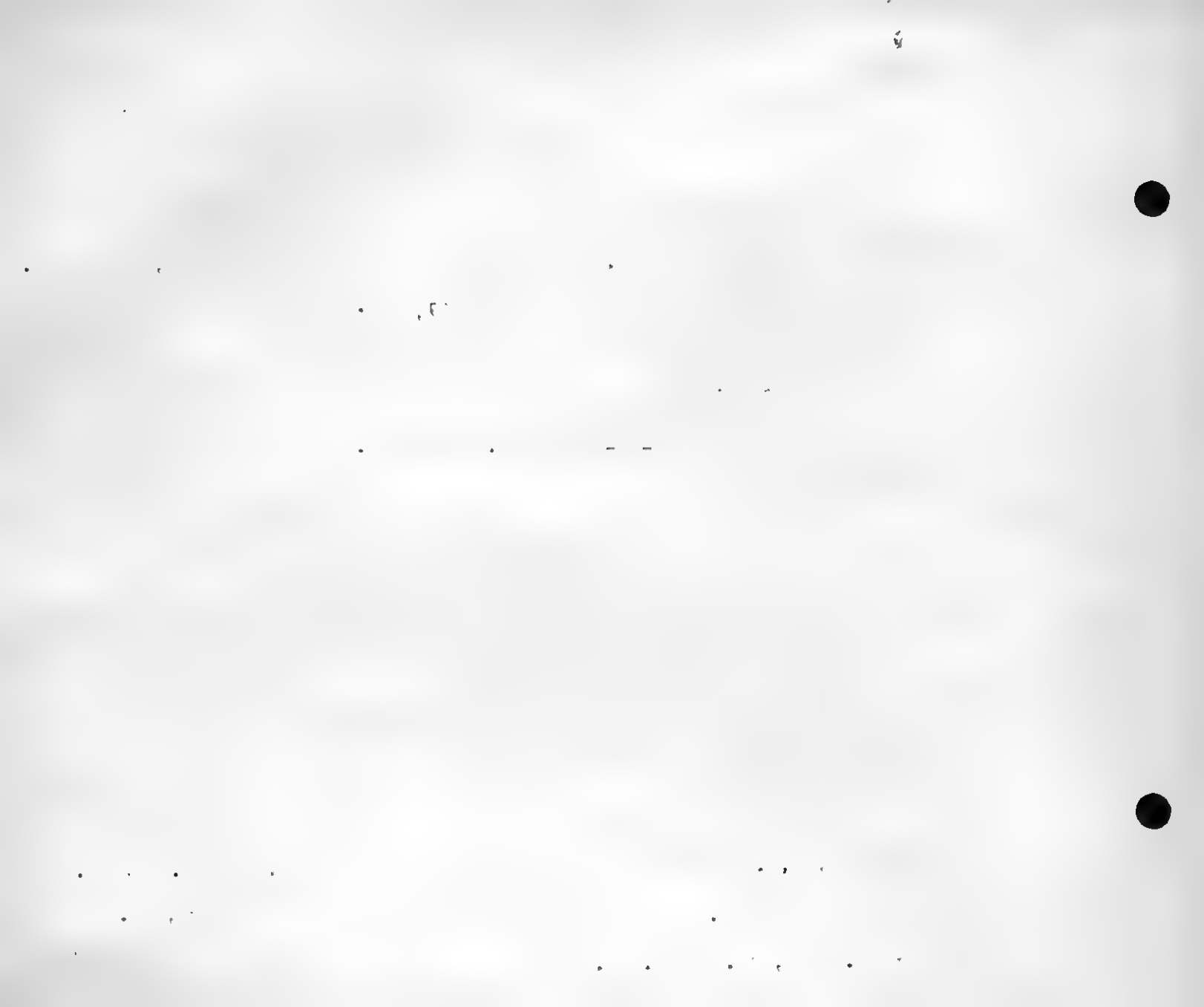
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #13 Film #3-1-1764, Dh

10668

CERTIFICATE OF DEATH

10669

| | | | | | | | |
|---|----------------------------------|--|---|---|---|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2903 Hiss Avenue | | | | d. STREET ADDRESS 2903 Hiss Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First MARY Middle A. Last LUBY | | | | 4. DATE OF DEATH Month August 1, Day 1967. | | | |
| 5 SEX Female | 6. COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH May 21, 1911. | | 9 AGE (In years last birthday) yrs. 56 | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (County & State, or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY USA | |
| 13. FATHER'S NAME Michael Spinnato 219-30-3540 | | | | 14. MOTHER'S MAIDEN NAME Catherine Marianna | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219-38-3540 | | 17. INFORMANT Mr. Maurice A. Luby | | Address (Same) | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO (b) CEREBRAL ARTERIO SCLEROSIS DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH Sudden 2 yrs | |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CORONARY ARTERY DISEASE | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10/3 , 1965, to 8/1 , 1967 that (I) (we) last saw the deceased alive on 8/1 1967, and that death occurred at 5:30 PM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Dr. L.P. Berger | | | | 22b. DATE SIGNED 8/1/67 | | 22c. PHYSICIAN'S NAME (Type) Dr. L.P. Berger | |
| 22d. ADDRESS 8100 Harford Rd., Balto. 34, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/5/67. | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | 25a. REC'D BY REGISTRAR DATE AUG 2 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10669

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town)

Dundalk

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived, if last institution, residence before admission)

a. STATE

Md.

b. COUNTY

Baltimore

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Dundalk

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

6824 Youngstown Ave. Balto., 22, Md

e. STREET ADDRESS

6824 Youngstown Ave., Balto., 22, Md

f. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

LAURA

VIOIA

LUTTRELL

4. DATE OF DEATH

August

Day

5

Year

1967

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

☒ NEVER MARRIED ☐

8. DATE OF BIRTH

June 22, 1918

9. AGE (In years last birthday)

49

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Work

10b. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Antonio Misciwozewski

14. MOTHER'S MAIDEN NAME

Laura

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

16. SOCIAL SECURITY NO.

217-16-8520

17. INFORMANT

Thomas R. Luttrell

Address

Same.

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(c)

Cirrhosis of liver

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

None

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Melvin B. Davis

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

6800 Morningside Rd.

Balto., 21222, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

8-8-67

22c. NAME OF CEMETERY OR CREMATORY

Oak Lawn Cemetery

22d. LOCATION (City, town, or country)

7225 Eastern Blvd., Ba.Co., Md.

23. FUNERAL DIRECTOR

Charles S. Zeiler

6224 Eastern Ave. Balto., 21224, Md.

24a. REC'D BY REGISTRAR

AUG 8 1967

24b. REGISTRAR'S SIGNATURE

Charles Judge

Handwritten text at the top of the page, mostly illegible.

1

2

3

4-5

6

7

8

9

10

11

12

13

14

15

16

17-18

19

20

21-22

23

24

25

26

27

28

29

30

31

32

33

34

35

36-37

38

39

40

41

42

43

44

45

46-47

48

49

50

51

52

53

54



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|--|--|---|----------------------|---|--|---|--|---|-------------------|--------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 8209 Laurel Drive d. STREET ADDRESS 8209 Laurel Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) ANNA | | | First ROSE | | | Middle MAGGITT | | | Last 11 | | |
| 4. DATE OF DEATH August | | Month 11 | | Day 1967 | | Year 1967 | | 5. SEX Female | | 6. COLOR OR RACE Caucasian | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH 10/8/04 | | 9. AGE (In years last birthday) 62 yrs. | | IF UNDER 1 YEAR Months 11 | | IF UNDER 24 HRS. Days 11 | | Hours 11 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY --- | | 11. BIRTHPLACE (County & State, or foreign country) New York, New York | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Salvatore Caomo | | | | | | 14. MOTHER'S MAIDEN NAME Sarrese, Josephine | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 214-24-6477 | | 17. INFORMANT Julio Maggitti | | Address --- | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Lymphosarcoma 2001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from July 12, 1967 , to August 11, 1967 , that (I) (we) last saw the deceased alive on August 11, 1967 , and that death occurred at 12:38 AM, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE John E. Adams | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 8/11/67 | | | |
| 22c. PHYSICIAN'S NAME (Type) John E. Adams, M.D. | | | | | | 22d. ADDRESS Greater Baltimore Medical Center | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Intombment | | 23b. DATE THEREOF 8/16/67 | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum | | | | 23d. LOCATION (City, town or county) (State) Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR L J Ruck Inc. | | | | ADDRESS Balto 14 Md. | | 25a. REC'D BY REGISTRAR AUG 15 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

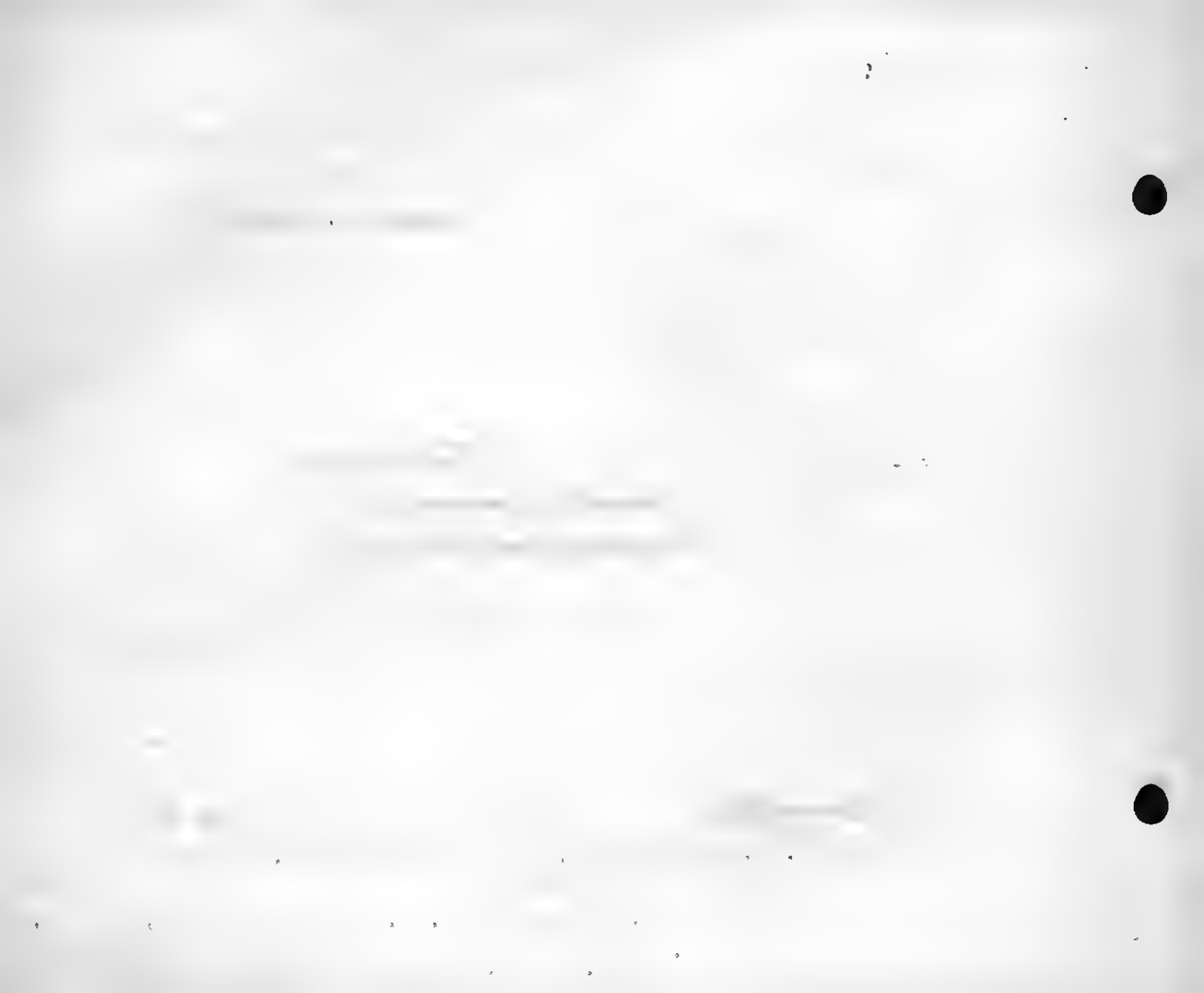
10671

CERTIFICATE OF DEATH

10672

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | c. LENGTH OF STAY IN 1b <u>20da</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Med. Center</u> | | d. STREET ADDRESS <u>3501. ST. PAUL ST.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Olive Dashiell Martin</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Cau</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/27/1894</u> 72 |
| 9. AGE (In years lost in Joy) <u>72</u> YES | | 10. BIRTHPLACE (County & State, or foreign country) <u>Princess Ann, Md</u> | |
| 11. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Francis Dashiell</u> | | 14. MOTHER'S MAIDEN NAME <u>Dashiell</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>220-05-5140</u> | |
| 17. INFORMANT <u>Patients Chart</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO (b) <u>Nasopharyngeal Carcinoma</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/25</u> , 19 <u>67</u> , to <u>8/14</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>8/13</u> , 19 <u>67</u> , and that death occurred at <u>1:55AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>D. C. Malrik</u> | | 22b. DATE SIGNED <u>8.14.67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>D. C. Malrik, M.D.</u> | | 22d. ADDRESS <u>Greater Balto. Medical Center</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE HEREOF <u>8/17/1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Andrew's Epis. Ch.</u> | 23d. LOCATION (City or town) (County) (State) <u>Princess Anne, Md.</u> |
| 24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| ADDRESS <u>4905 York Road</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| <u>Balto. 12, Md.</u> | | DATE <u>AUG 15 1967</u> | |



10673

10672

VR A15 (4)
20M 1/65

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown Rd</u> | | c. LENGTH OF STAY IN 1b <u>Reisterstown Rd</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greenspring Ave. at Dover Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Curtis Granville McCabe, Sr.</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>1967</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>August 11, 1903</u> |
| 9. AGE (In years last birthday) <u>64</u> yrs. | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | 11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Building Inspector</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Balco Co., Md.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>James A. McCabe</u> | | 14. MOTHER'S MAIDEN NAME <u>Lola Lindsay</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>220-18-808</u> | |
| 17. INFORMANT <u>Family Records</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 7 x 11 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive C.V.A.D.</u> DUE TO (c) <u>decompensation</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-1-1967</u> to <u>8-16-1967</u> , that (I) (we) last saw the deceased alive on <u>8-16-1967</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>James H. Saffell</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>James H. Saffell MD</u> | | 22d. ADDRESS <u>Reisterstown, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | | 23b. DATE THEREOF <u>Aug. 19, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Grace Falls d. Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Pockessville, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u> | | 25a. REC'D BY REGISTRAR DATE <u>AUG 21 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u> | |

CERTIFICATE OF DEATH

10674

Reg. Dist. No.

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Balto. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Md. b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2908 Emerald Rd. | | d. STREET ADDRESS 2908 Emerald Rd. | |
| 3. NAME OF DECEASED (Type or print) Viola First Middle Last McCammon | | 4. DATE OF DEATH Month 8/ Day 26 Year 1967 | |
| 5. SEX F. | 6. COLOR OR RACE W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 18, 1887 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Riley | | 14. MOTHER'S MAIDEN NAME Elizabeth Moore | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 218-54-0895 | |
| 17. INFORMANT Mrs. Lois Lambdin | | Address same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Cerebral arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis | | | INTERVAL BETWEEN ONSET AND DEATH 5 days 6 hrs |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 1966 to Aug 26, 1967 that I last saw the deceased alive on August 25, 1967 , and that death occurred at 6:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6077 Harford Rd. Balto., Md 21214 DATE SIGNED 8-26-67 | | | |
| ACTUAL SIGNATURE Ronald J. Jandoy | | PHYSICIAN'S NAME (Type) Balto., Md 21214 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 8/30/67 | 22c. NAME OF CEMETERY OR CREMATORY Loudon Pk. Cem. | 22d. LOCATION (City, town, or county) (State) Balto., Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck Inc. | | ADDRESS Balto., Md. | |
| 24a. REC'D BY REGISTRAR AUG 28 1967 | | 24b. REGISTRAR'S SIGNATURE Charles Judge | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10674

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10675

| | | | |
|--|---------------------------------------|--|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institut on Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN IL Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital | | d. STREET ADDRESS 3116 Abell Ave. | |
| 3 NAME OF DECEASED (Type or print) Albert | | 4 DATE OF DEATH Month August Day 10 Year 1967 | |
| 5 SEX M | 6 COLOR OR RACE W | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 3/5/1903 |
| 9 AGE (In years lost birthday) 64 yrs | | 10 UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY Hausewald's Bakery Penna. | |
| 11 BIRTHPLACE (State or foreign country) U.S.A. | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME Day id McCready | | 14 MOTHER'S MAIDEN NAME Catherine Wyant | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16 SOCIAL SECURITY NO 192-09-6527 | |
| 17 INFORMANT Mrs. Rebecca E. McCready | | Address (Same) | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Occlusion DUE TO Coronary Insufficiency (c) 24 yrs | | INTERVAL BETWEEN ONSET AND DEATH 24 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | |
| 20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21 I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles F. O'Donnell, M.D. | | 22. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/12/1967 | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith | 23d. LOCATION (City or Town) (County) (State) Baltimore Md. |
| 24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | 25a. REC'D BY REGISTRAR DATE AUG 11 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE William Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---------------------------|--|---|--|---|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 10675 Item #2 a, c & d minor. taken from birth cert. ph 10676 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Baltimore | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore | | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 21218 | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center | | | | | | d. STREET ADDRESS 2611 Maryland Ave. 6701 North Charles Street | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Female McDaniel | | | | | | 4. DATE OF DEATH Month Day Year 8 6 19 67 | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE Cauc. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7/26/67 | | 9. AGE (In years last birthday) 11 days | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Holland E. McDaniel | | | | | | 14. MOTHER'S MAIDEN NAME Frieda Pipkin | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal obstruction | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Meconium ileus | | | | | | | | | | | |
| DUE TO (c) Prematurity | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/26, 1967, to 8/6, 1967, that (I) (we) last saw the deceased alive on 8/6 1967, and that death occurred at 7:10 PM, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE [Signature] | | | | | | | | | | 22b. DATE SIGNED 8/9/67 | |
| 22c. PHYSICIAN'S NAME (Type) Rudiger Breiteneker, M.D. | | | | | | 22d. ADDRESS Greater Baltimore Medical Center | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY GBMC | | | | 23d. LOCATION (City, town or county) (State) Baltimore Md | |
| 24. FUNERAL DIRECTOR GBMC | | | | | | 25a. REC'D BY REGISTRAR AUG 11 1967 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-100-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10676

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10677

| | | | | | |
|--|---------------------------------|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXXXXXXXX | | c. LENGTH OF STAY IN b 9 yrs | | 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXXXXXXXX Parkville | |
| d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) 1109 Deanwood | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last BENJAMIN PIERCE McDONALD | | | 4 DATE OF DEATH Month Day Year August 19 1967 | | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Dec 10 1917 | 9 AGE (In years last birthday) 49 yrs | 10 UNDER 1 YEAR Months Days Hours Min 19 67 |
| 10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent | | 10b. KIND OF BUSINESS OR INDUSTRY Bendix-Friez | | 11 BIRTHPLACE (State or foreign country) Maryland | |
| 12 CITIZEN OF WHAT COUNTRY? USA | | 13 FATHER'S NAME Kenneth McDonald | | | |
| 14 MOTHER'S MAIDEN NAME | | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW2 | | | |
| 16 SOCIAL SECURITY NO | | 17 INFORMANT Family Records | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) | |
| 20f. (City or town) (County) (State) | | 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| 22. DATE SIGNED August 19, 1967 | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | |
| 23b. DATE THEREOF 8-23-67 | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial | | 23d. LOCATION (City or town) (County) (State) Balto Co MD | |
| 24 FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford Rd. | | 25a. REC'D BY REGISTRAR AUG 22 1967 | | 25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10677

10678

| | | | |
|---|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 0-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | 2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 7620 York Road #21204 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) (SR. M. Benezetta, OSF) First Middle Last Helen E. McGee | | 4 DATE OF DEATH Month Day Year August 28 19 67 | |
| 5 SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 14, 1886 |
| 9. AGE (n years last birthday) 81 yrs | | 10. F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Religious | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (County & State, or foreign country) Pennsylvania | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13 FATHER'S NAME Patrick McGee | | 14. MOTHER'S MAIDEN NAME Bridget Harkins | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 218-54-3311 | |
| 17. INFORMANT St. Joseph's Hospital Records | | Address (Same) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO 26CX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Diabetes mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from April 11, 1967 , to August 28, 1967 , that (I) (we) last saw the deceased alive on August 28, 1967 , and that death occurred at 6:05 AM from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Gualberto C. Gokim, Jr.</i> | | 22b. DATE SIGNED August 28, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Gualberto Gokim, M.D. | | 22d. ADDRESS 7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/31/67. | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. |
| 24 FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | 25a. REC'D BY REGISTRAR DATE AUG 29 1967 | |
| 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10678

CERTIFICATE OF DEATH

10679

| | | | | | | | |
|---|----------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Louisiana c. LENGTH OF STAY IN 1b 12 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY A. A. Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie d. STREET ADDRESS 7811 Winborne Dr., Apt. H e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Cyril J. McHale | | | | 4. DATE OF DEATH Month August Day 15 Year 1967 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 8, 1923 | 9. AGE (in years last birthday) 44 yrs | 10. IF UNDER 1 YEAR Months 4 Days 15 Hours 15 Min 00 | 11. IF UNDER 24 HRS Hours 15 Min 00 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamship Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Lines | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME William McHale | | | | 14. MOTHER'S MAIDEN NAME Mary Flynn | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO 216-12-3133 | | 17. INFORMANT Mr. John McHale Address 1312 E. Fort Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) uremia DUE TO (c) chronic glomerulonephritis. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 3, 1967 , to August 15, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 15, 1967 , and that death occurred at 5:25AM , from causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE Lawrence F. Misanik, M.D. | | | 22b. DATE SIGNED August 15, 1967 | | 22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/18/67 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | |
| 24. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc 1501 East Fort Avenue | | | | 25a. REC'D BY REGISTRAR AUG 16 1967 | | 25b. REGISTRAR'S SIGNATURE J. Charles Jones | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10680

10679

| | | | | | |
|--|--|--|---|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | c. LENGTH OF STAY IN 1b Life | | 2 USUAL RESIDENCE (Where he resided lived if institution Residence before admission) a. STATE Maryland b. COUNTY 21206 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | d. STREET ADDRESS 5812 Benton Heights Ave. | |
| 3 NAME OF DECEASED (Type or print) First Martin Middle Joseph Last Mc Hale | | 4 DATE OF DEATH Month 8 Day 30 Year 67 | | | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 8/28/1967 | 9. AGE (In years last birthday) yrs 2 | IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min 19 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (County & State, or foreign country) Towson | |
| 13 FATHER'S NAME Martin Joseph McHale | | 14. MOTHER'S MAIDEN NAME Gertrude Maria Wustmann | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO | | 17. INFORMANT Father, above Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple congenital anomalies. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) | (County) | (State) |
| 21 I certify that (I) (this hospital) attended the deceased from 8/28 , 19 67 , to 8/30 , 19 67 , that (I) (we) last saw the deceased alive on 8/30 , 19 67 , and that death occurred at 8:05 PM , from causes and on the date stated above. | | | | | |
| 22a SIGNATURE <i>Lawrence F. Misanik</i> | | M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b. DATE SIGNED August 31, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D. | | 22d. ADDRESS 7620 York Rd., Towson, Md. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 9/1/67 | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md | | |
| 24 FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane | | 25a. RECEIVED BY REGISTRAR SEP 5 1967 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

10680

CERTIFICATE OF DEATH

10681

| | | | |
|--|--|---|---|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PH</u> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | c LENGTH OF STAY IN 1b <u>years</u> | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chesapeake Manor Nursing Home</u> | | e STREET ADDRESS <u>211 Murdock Road</u> | |
| 3 NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Barton</u> Last <u>McLay</u> | | 4. DATE OF DEATH Month <u>8</u> Day <u>31</u> Year <u>1967</u> | |
| 5 SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>1-25-1893</u> |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> | | 10b KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 9. AGE (In years last birthday) <u>74</u> yrs |
| 11 BIRTHPLACE (County & State, or foreign country) <u>Quincy Mass</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>James Barton</u> | | 14. MOTHER'S MAIDEN NAME <u>Atkinson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u> | | 16 SOCIAL SECURITY NO. <u>215-10-4448</u> | |
| 17. INFORMANT <u>Mr. John W. C. McLay, Same as # 2</u> | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4221</u> DUE TO (b) <u>CARDIO-</u> DUE TO (c) <u>ARTERIOSCLEROTIC VASCULAR DISEASE</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/20</u> , 19 <u>67</u> , to <u>8/30</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>8/22</u> , 19 <u>67</u> , and that death occurred at _____ M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Luis J. Elias M.D.</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>LUIS J. ELIAS M.D.</u> | | 22d. ADDRESS <u>1701 MERIDENE DR.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>Sept. 2, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Grove Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore Co., Maryland</u> |
| 24 FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204</u> | | 25a. REC'D BY REGISTRAR DATE <u>SEP 5 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10681

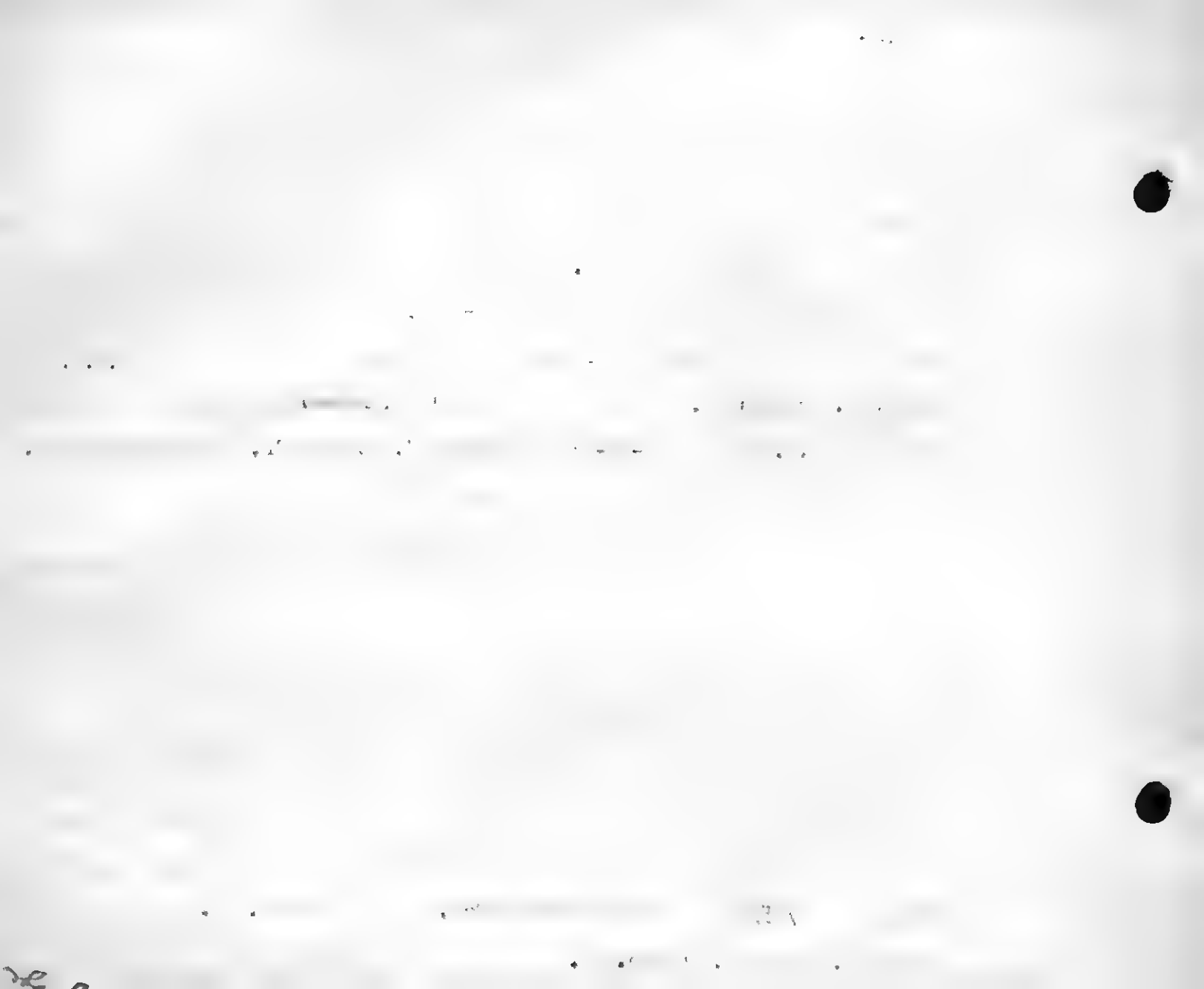
CERTIFICATE OF DEATH

10682

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|-------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 21212 | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Res. before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 5515 The Alameda e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Lawrence E. McQUAID | | 4. DATE OF DEATH Month August Day 23 Year 1967 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-26-1917 |
| 9. AGE (In years last birthday) 49 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | 11. BIRTHPLACE (County & State, or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Charles J. McQuaid Sr. | |
| 14. MOTHER'S MAIDEN NAME Ella G. McQuaid Tarlton | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes W.W.II | |
| 16. SOCIAL SECURITY NO 217-05-5338 | | 17. INFORMANT Charles J. McQuaid Jr. Address 3522 Parklawn Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) acute myocardial infarction (c) coronary thrombosis INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. B.T.T. <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/18/ 1967, to 8/23/ 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/23/ 1967, and that death occurred at 8:35 M, from causes and on the date stated above. | |
| 22a. SIGNATURE <i>James J. Mesarik</i> | | 22b. DATE SIGNED August 23, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Lawrence F. Mesarik, M.D. | | 22d. ADDRESS 7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/25/67 | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. | 23d. LOCATION (City or Town) (County) (State) Balto. Md. |
| 24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. | | 25a. REC'D BY REGISTRAR DATE AUG 24 1967 | |
| 25b. REGISTRAR'S SIGNATURE <i>Charles Jr.</i> | | | |



10682

CERTIFICATE OF DEATH

10683

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN TB 2 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | e. STREET ADDRESS 927 BENEFIT STREET | |
| 3. NAME OF DECEASED (Type or print) First Middle Last DANIEL SETH MC QUAY | | 4. DATE OF DEATH Month Day Year AUGUST 15, 1967 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/21/94 |
| 9. AGE (In years last birthday) yrs. 72 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAXI DRIVER | |
| 11. BIRTHPLACE (County & State, or foreign country) BOGMAN, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME DANIEL MC QUAY | | 14. MOTHER'S MAIDEN NAME EMILY FAULKNER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWI | | 16. SOCIAL SECURITY NO 217 07 59 42 | |
| 17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH DAYS | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EMPHYSEMA | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that the (this hospital) attended the deceased from AUGUST 13, 1967 , to AUGUST 15, 1967 , that the (we) last saw the deceased alive on AUGUST 15, 1967 , and that death occurred at 1:45 PM , from causes and on the date stated above | | | |
| 22a. SIGNATURE <i>J. D. Talbert</i> | | 22b. DATE SIGNED 8/16/67 | |
| 22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D. | | 22d. ADDRESS VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 8 19 67 | 23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN CEMETERY | 23d. LOCATION (City or Town) (County) (State) GLEN BURNIE, MD. |
| 24. FUNERAL DIRECTOR MC CULLY FUNERAL HOME | | 25. RECEIVED BY REGISTRAR AUG 17 1967 | |
| 25a. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

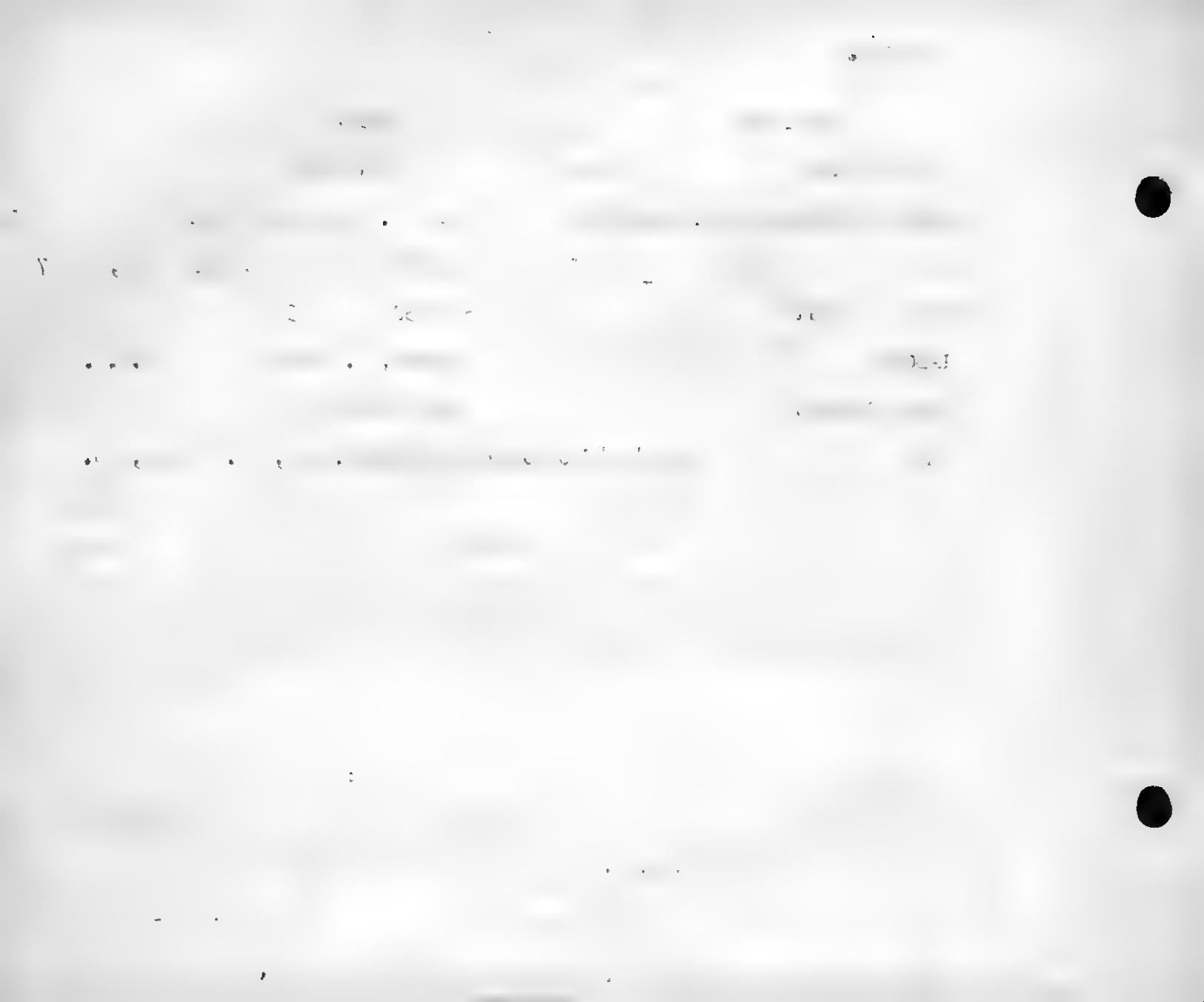
Item #23b **CERTIFICATE OF DEATH**

10683

10634

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY _____ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN lb 30 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | e. STREET ADDRESS 2577 E. BALTIMORE STREET | |
| 3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH NMI MELLETTE | | 4. DATE OF DEATH Month Day Year AUGUST 24, 1967 | |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/21/32 |
| 9. AGE (In years last birthday) yrs 35 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | |
| 11. BIRTHPLACE (County & State, or foreign country) SUMTER, S. CAROLINA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JAMES MELLETTE | | 14. MOTHER'S MAIDEN NAME ABBIE MURRAY | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES | | 16. SOCIAL SECURITY NO 247 48 47 09 | |
| 17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO (b) DIABETIC NEPHROPATHY DUE TO (c) DIABETES MELLITUS | | INTERVAL BETWEEN ONSET AND DEATH MONTHS YEARS YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UREMIC GASTRITIS | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (X) (this hospital) attended the deceased from 7/25/67 , 19 67 to 8/24/67 , 19 67 , that (X) (we) lost saw the deceased alive on 8/24/67 , 19 67 , and that death occurred at 4:35A M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Neilson Neilson</i> | | 22b. DATE SIGNED 8/24/67 | |
| 22c. PHYSICIAN'S NAME (Type) NEILSON NEILSON, M. D. | | 22d. ADDRESS VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 9/29/67 | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND |
| 24. FUNERAL DIRECTOR MC CRIMMON FUNERAL HOME | | 25a. REC'D BY REG. STRA AUG 25 1967 | |
| 25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i> | | 25c. REGISTRAR'S SIGNATURE <i>Charles J. J...</i> | |

2302 W. NORTH AVENUE, BALTIMORE, MD.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10684

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10685

| | | | | | | | |
|---|----------------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Balto.</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown</i> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Reisterstown</i> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Westminster Road</i> | | | | d. STREET ADDRESS <i>Kemp Road</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>E.</i> Last <i>Merryman</i> | | | | 4. DATE OF DEATH Month <i>August</i> Day <i>20</i> Year <i>1967</i> | | | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Dec. 31, 1933</i> | 9. AGE (In years and birthday) <i>33</i> yrs | 10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> | | 11. IF UNDER 24 HRS Hours <i>0</i> Min <i>0</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Virginia</i> | | 12. CITIZEN OF WHAT COUNTRY <i>USA</i> | |
| 13. FATHER'S NAME <i>Jake B. Wade</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Ruth A. Salyer</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO <i>218-32-2796</i> | | 17. INFORMANT <i>Mr. Gilbert A. Merryman</i> Address <i>Reisterstown, Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Lacerations of face & throat; Fractured rt. elbow; Multiple fractures of facial bones</i> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>1 min.</i> |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <i>Apparent driver of car involved in 2 car collision</i> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <i>2:40 p.m. Aug 20 1967</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Westminster Rd.</i> | | 20f. (City or town) (County) (State) <i>Reisterstown Balto Md.</i> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <i>D. D. Caples</i> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <i>D. D. Caples, M. D.</i> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 6 Hanover Rd. Address <i>Reisterstown, Md.</i> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>Aug. 23, 1967</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>New Oakland</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Sykesville, Md.</i> | |
| 24. FUNERAL DIRECTOR <i>J. F. Eline & Sons</i> Address <i>Reisterstown, Md.</i> | | | | 25a. REC'D BY REGISTRAR DATE <i>AUG 23 1967</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

10685

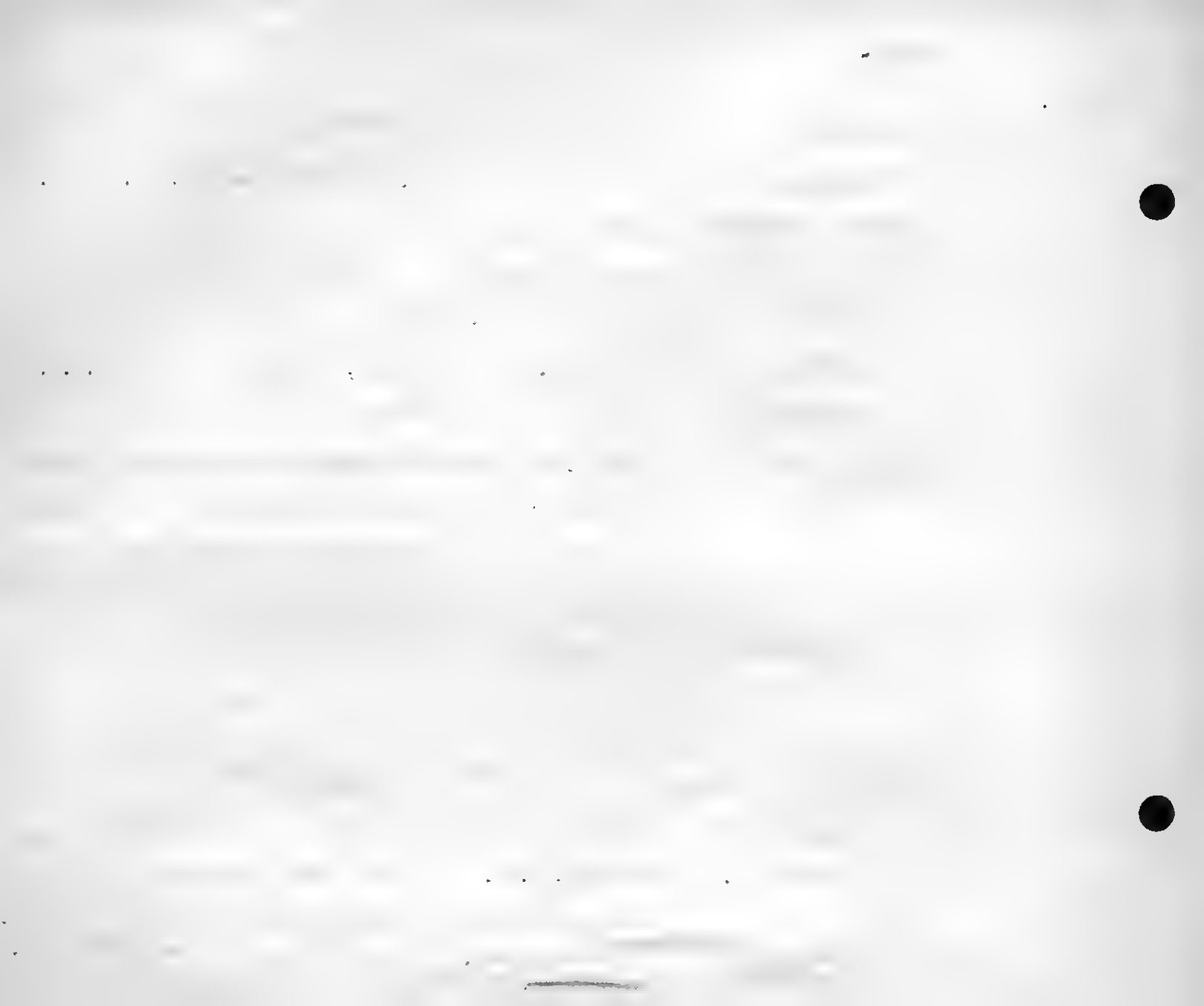
CERTIFICATE OF DEATH

10686

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|---------------------------------|--|-----------------------------------|--|--|--|--|
| 1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY 11 | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN 'b | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT 3 BOX 482 PASADENA, MD. AA CO. | | | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) VETERANS ADMINISTRATION HOSPITAL | | | | d STREET ADDRESS RT 3 | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) HARRY PATRICK MICHAELS | | | | 4 DATE OF DEATH Month AUGUST Day 3 Year 19 67 | | | |
| 5 SEX MALE | 6 COLOR OR RACE WHITE | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 3/17/99 | | 9 AGE (In years lost birthday) 68 yrs | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR | | 10b KIND OF BUSINESS OR INDUSTRY TRUCKING CO. | | 11 BIRTHPLACE (County & State or foreign country) BALTIMORE, MARYLAND | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME EMILE MICHAELS | | | | 14. MOTHER'S MAIDEN NAME MARGARET JONES | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES ARMY | | 16 SOCIAL SECURITY NO 215 03 59 24 | | 17 INFORMANT CLINICAL RECORDS VAH FORT HOWARD, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA FACE AND NECK WITH METASTASIS DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1910 | | | | | | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE | | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from JULY 25 , 19 67 , to AUGUST 3 , 1967, that (I) (we) last saw the deceased alive on AUGUST 3 , 19 67 and that death occurred at 9:40 AM from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>George C. McElpatrick</i> | | | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b. DATE SIGNED AUGUST 3, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK, M. D. | | | | 22d ADDRESS VAH FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b DATE THEREOF | | 23c NAME OF CEMETERY OR CREMATORY (SINGLETON) BALTIMORE NATIONAL CEMETERY | | 23d LOCATION (City or Town) (County) (State) FREDERICK AVEN. | |
| 24 FUNERAL DIRECTOR SINGLETON FUNERAL HOME <i>Robert Wilson</i> | | | | 25a RECD BY REGISTRAR AUG 7 1967 <i>Charles Young</i> | | 25b REGISTRAR'S SIGNATURE BALTIMORE, MD. | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

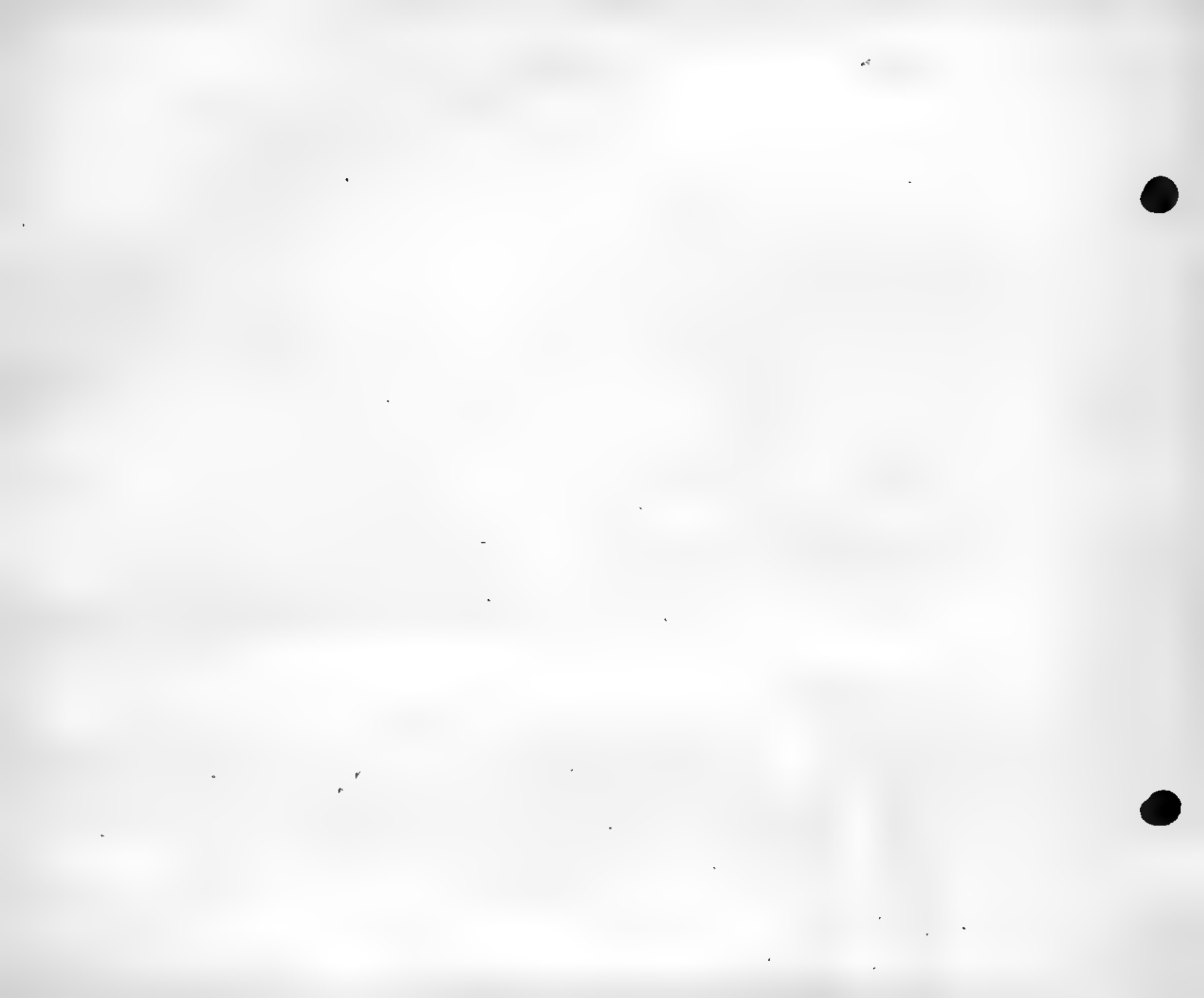
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10686

CERTIFICATE OF DEATH

10687

| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE | | c. LENGTH OF STAY IN 1b 4 YEARS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MASONIC HOME | | d. STREET ADDRESS 4911 1/2 BELAIR ROAD | |
| 3 NAME OF DECEASED (Type or print) First Middle Last EMMA LOU MILLER | | 4 DATE OF DEATH Month Day Year AUG 1 1967 | |
| 5. SEX FE | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/26/81 |
| 10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U. S | |
| 13. FATHER'S NAME JOHN HENRY MILLER | | 14. MOTHER'S MAIDEN NAME SUSAN WHITEMORE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 217-07-7791 | |
| 17. INFORMANT MASONIC HOME RECORDS | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Arteriosclerotic heart disease DUE TO (b) 2. Cerebral arteriosclerosis DUE TO (c) 3. Extreme Senility & fracture Rt. Hip | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4. BRONCHOPNEUMONIA, terminal | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from August 1, 1965 to July 31, 1967 , that (I) (we) last saw the deceased alive on July 31, 1967 , and that death occurred at 6:39 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE JAMES HAD HAMED | | 22b. DATE SIGNED 8/1/67 | |
| 22c. PHYSICIAN'S NAME (Type) JAMES HAD HAMED | | 22d. ADDRESS MASONIC HOME | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF Aug. 4, 1967 | 23c. NAME OF CEMETERY OR CREMATORY MT Zion's Lutheran | 23d. LOCATION (City or Town) (County) (State) FREDERICK Co. Md |
| 24. FUNERAL DIRECTOR Wm Cook - Brooks Towson | | 25a. REC'D BY REGISTRAR Towson Md | |
| 25b. REGISTRAR'S SIGNATURE Juanita Jones | | DATE AUG 4 1967 | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

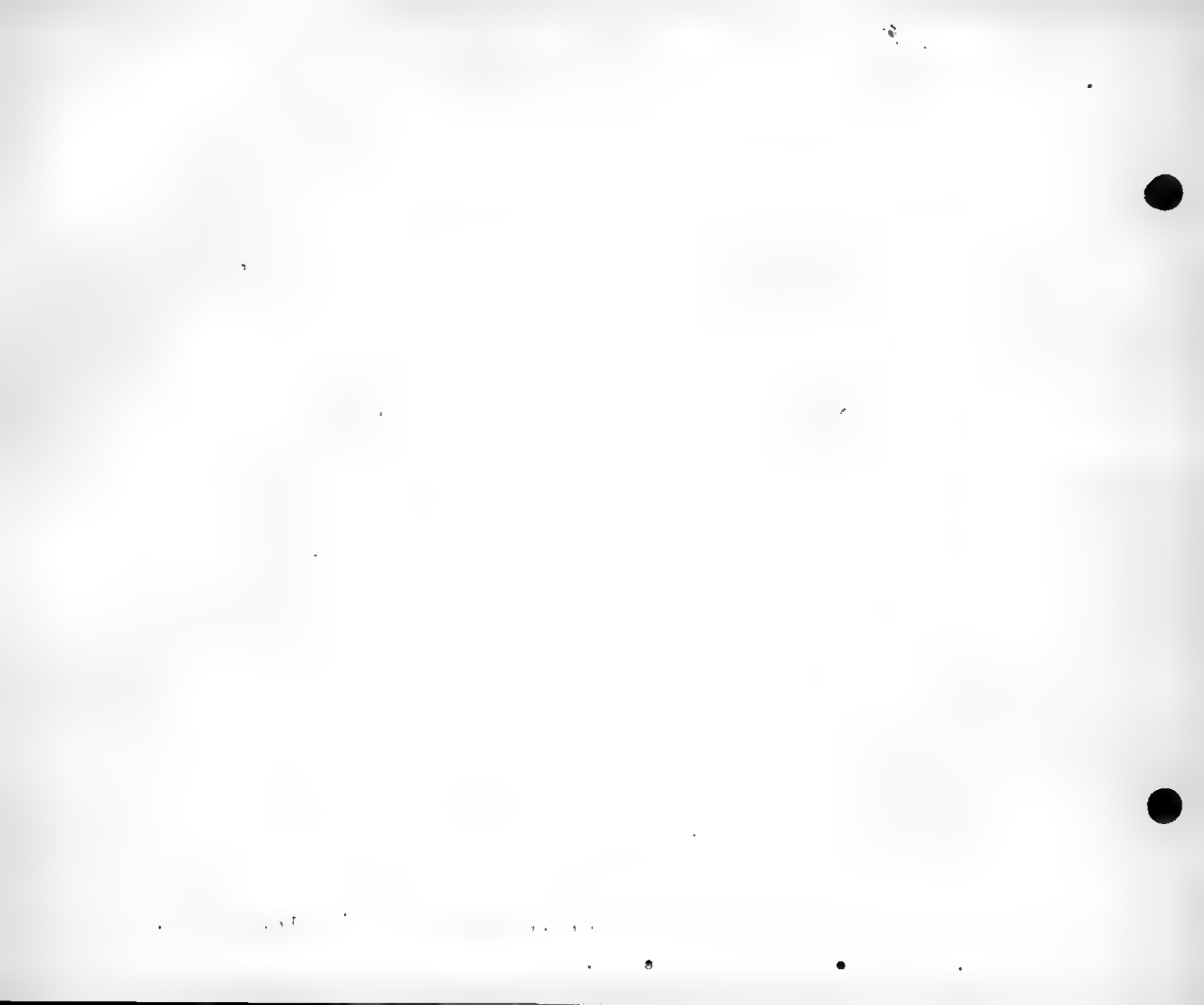
10688

10687

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|---|---|--|
| 1 PLACE OF DEATH a COUNTY <i>Balto</i> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a STATE <i>Virginia</i> b COUNTY <i>W</i> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>mt Wilson</i> | | c LENGTH OF STAY in lb <i>3 hrs 40 min</i> | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>mt Wilson State Hosp.</i> | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First <i>HENRY</i> Middle <i>MILLER</i> Last <i>MILLER</i> | | 4. DATE OF DEATH Month <i>aug</i> Day <i>5</i> Year <i>1967</i> | |
| 5 SEX <i>M.</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>3/21/06</i> |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 9. AGE (In years, last birthday) <i>61</i> yrs | |
| 10b KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (State or foreign country) <i>Virginia</i> | |
| 13 FATHER'S NAME <i>Joseph Miller</i> | | 12 CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <i>No</i> | | 14 MOTHER'S MAIDEN NAME <i>Amy Sheffey</i> | |
| 16 SOCIAL SECURITY NO | | 17 INFORMANT <i>mt Wilson Hosp. Records</i> Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-Pulmonary Collapse</i> DUE TO (b) <i>Pulmonary T.B - far adv. - active</i> DUE TO (c) <i>3 yrs</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>none</i> | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <i>none</i> | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. <i>none</i> p.m. <i>none</i> | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>E. L. Caples</i> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <i>D. D. CAPLES M.D.</i> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | Address (Street, city town, or county) | |
| 22. DATE SIGNED <i>8/5/67</i> | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 23b. DATE THEREOF <i>8/8/67</i> | 23c NAME OF CEMETERY OR CREMATORY <i>West End Cemetery</i> | 23d LOCATION (City or Town) (County) (State) <i>Wytheville, Va.</i> |
| 24 FUNERAL DIRECTOR <i>Wm. Cook-Brooks Inc Baltimore, Md. 21202</i> | | 25a REC'D BY REGISTRAR DATE <i>AUG 9 1967</i> | |
| | | 25b REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10689

10688

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville, Maryland c. LENGTH OF STAY IN 1b 1mth10dys | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore City 21230 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital | | d. STREET ADDRESS 501 E. Fort Avenue | |
| 3. NAME OF DECEASED (Type or print) John Moran Miller | | 4. DATE OF DEATH Month August Day 23 Year 19 67 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 18, 1906 |
| 9. AGE (In years last birthday) 61 yrs. | | IF UNDER 1 YEAR Months 7 Days 19 Hours 67 Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Paper Co. | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Charles Miller | | 14. MOTHER'S MAIDEN NAME Marguerita Schuman | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown | | 16. SOCIAL SECURITY NO 216-09-5110 | |
| 17. INFORMANT Records: Spring Grove State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 163X IMMEDIATE CAUSE (a) Brain Tumors, metastatic from (b) DUE TO (b) Carcinoma of the Lung (histopathology unk.) DUE TO (c) 7 mos | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o m 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that he (this hospital) attended the deceased from July 13, 1967 , to Aug. 23, 1967 , that he (we) last saw the deceased alive on Aug. 23, 1967 , and that death occurred at a. M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Anthony J. Young</i> | | 22b. DATE SIGNED 8-23-67 | |
| 22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D. | | 22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8 26 67 | 23c. NAME OF CEMETERY OR CREMATORY Landon Park | 23d. LOCATION (City or Town) (County) (State) Balto. Md. |
| 24. FUNERAL DIRECTOR Mc Cully | | 25a. REC'D BY REGISTRAR 130 E. Fort Ave | |
| 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | DATE AUG 24 1967 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1003. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (1)
6M 1/67

10689

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10680

| | | | |
|---|---------------------------------|--|---|
| 1 PLACE OF DEATH a COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Baltimore | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c LENGTH OF STAY IN 1b Hour | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | e STREET ADDRESS 2346 York Rd. | |
| 3 NAME OF DECEASED (Type or print) JOSEPH ADY MILLER | | 4 DATE OF DEATH Month August Year 1967 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Jan. 28, 1916 |
| 9 AGE (In years last birthday) 51 yrs | | 10 IF UNDER 24 HRS Months 23 Days 19 Hours 1 Min 1 | |
| 11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Delicatessen (Owner) | | 11b KIND OF BUSINESS OR INDUSTRY Phoenix, Maryland | |
| 12 CITIZEN OF WHAT COUNTRY? U.S.A. | | 13 FATHER'S NAME Joseph C. Miller | |
| 14 MOTHER'S MAIDEN NAME Elizabeth Ady | | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | |
| 16 SOCIAL SECURITY NO 219-12-6810 | | 17 INFORMANT Mrs. Virginia H. Miller 2346 York Rd. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH Sudden | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour am 19 pm | | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspected on <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE OF EXAMINER Charles F. O'Donnell, M.D. | | 22 DATE SIGNED 8/23/67 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE THEREOF 8/26/67 | |
| 23c NAME OF CEMETERY OR CREMATORY Jessop Cemetery | | 23d LOCATION (City or Town) (County) (State) Cockeysville, Md. | |
| 24 FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204 | | 25a RECEIVED BY REGISTRAR AUG 30 1967 | |

10690

CERTIFICATE OF DEATH

10691

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| c. LENGTH OF STAY IN 16 4 yrs. 5 mo. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Stella Maris Hospice | | d. STREET ADDRESS 2017 Hillcrest Rd. 21207 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Louise Ann Miller | | 4. DATE OF DEATH Month Aug. Day 25 Year 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 14, 1895 |
| 9. AGE (In years, months, days) 71 yrs | | 10. IF UNDER 1 YEAR Months 1 Days 10 Hours 15 Min 00 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HWI. | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John C. Harting | | 14. MOTHER'S MAIDEN NAME Margaret Fleishhman | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO 214-16--6720B | |
| 17. INFORMANT Mary L. Miller - 3702 N. Rogers Ave | | Address Records Stella Maris Hospice | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 7-2-1 DUE TO (b) AscVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH 14 min. |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 3/5/65 , 19 65 , to 8/25/67 , 19 67 , that (I) (we) last saw the deceased alive on 8/22/67 , 19 67 , and that death occurred at 4A M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Robert J. Mahon | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Robert J. Mahon, M.D. | | 22d. ADDRESS 204 E. Joppa | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 8-28-67 | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md |
| 24. FUNERAL DIRECTOR Ells Worth Armacast | | 25a. REC'D BY REGISTRAR DATE AUG 28 1967 | |
| 25b. REGISTRAR'S SIGNATURE | | | |



10691

CERTIFICATE OF DEATH

10692

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|--|---|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | c. LENGTH OF STAY IN 'b' <u>3 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Caton Ridge Nursing Home</u> | | d. STREET ADDRESS <u>3 Ashmore Rd</u> | |
| 3 NAME OF DECEASED (Type or print) <u>Marie B. Mitzell</u> | | 4 DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>1967</u> | |
| 5 SEX <u>F</u> | 6 COLOR OR RACE <u>W</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>9/26/80</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9 AGE (In years last birthday) yrs <u>86</u> |
| 11 BIRTHPLACE (County & State or foreign country) <u>MD</u> | | 12 CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13. FATHER'S NAME <u>C. Peter Dorn</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Wheeler</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO <u>218-079789</u> | |
| 17. INFORMANT <u>My Home Chap</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>40 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Coronary Arteriosclerosis</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8/15</u> , 19 <u>67</u> , to <u>8/16</u> , 19 <u>67</u> that (I) (we) lost saw the deceased alive on <u>8/16</u> , 19 <u>67</u> , and that death occurred at <u>5:15</u> PM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>John E. J. [Signature]</u> | | 22b. DATE SIGNED <u>8/16/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>H. J. Schuchardt</u> | | 22d. ADDRESS <u>444 W. [Address]</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Aug. 19, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Mem. Gardens</u> | 23d. LOCATION (City or Town) (County) (State) <u>Finksburg, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>H. J. Schuchardt</u> | | 25a. REC'D BY REGISTRAR <u>Charles J. [Signature]</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10692

CERTIFICATE OF DEATH

10693

| | | | |
|---|--|--|--|
| 1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPARROWS POINT | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS 823 "I" STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First WALTER Middle J. Last MOORE | | 4 DATE OF DEATH Month AUGUST Day 11 Year 19 67 | |
| 5 SEX MALE | 6. COLOR OR RACE NEGRO | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-18-1901 9 AGE (In years to birthday) 66 |
| 10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER | | 10b. KIND OF BUSINESS OR INDUSTRY STEEL COMPANY | 11 BIRTHPLACE (County & State, or foreign country) ROCKSBORO, NORTH CAROLINA 12 CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME WILL MOORE | | 14. MOTHER'S MAIDEN NAME TINY PAILEY | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I | | 16. SOCIAL SECURITY NO 213 09 15 52 | 17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO ARTERIOSCLEROTIC HEART DISEASE (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTESTINAL OBSTRUCTION | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town, (County) (State) |
| 21. I certify that (x) (this hospital) attended the deceased from 7/5/67 , 19 67 , to 8/11/67 , 19 67 , that (x) (we) last saw the deceased alive on 8/11/67 , 19 67 , and that death occurred 11:20 PM on 8/11/67 , 19 67 , at the date stated above. | | | |
| 22a. SIGNATURE Milton Ginsberg | | 22b. DATE SIGNED 8/11/67 | |
| 22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M. D. | | 22d. ADDRESS VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 8-15-67 | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | 23d. LOCATION (City or town) (County) (State) BALTIMORE, MARYLAND |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR MORTEN & DYETT FUNERAL HOME DATE AUG 14 1967 BALTIMORE, MARYLAND | |

REGISTER'S SIGNATURE
Charles J. J...

10693

CERTIFICATE OF DEATH

10684

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

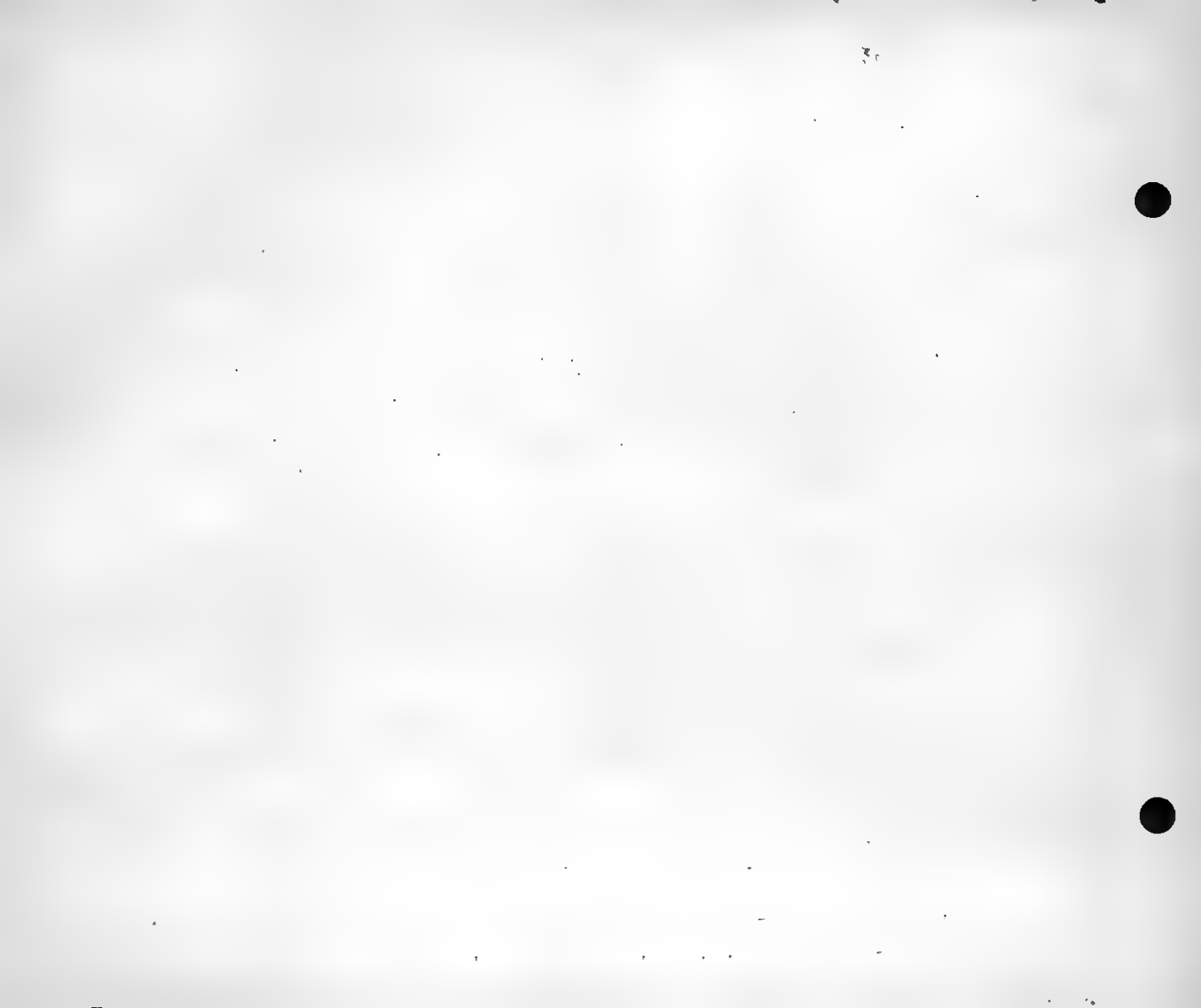
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON.</u> | | c. LENGTH OF STAY IN TB | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Appl. 2000-10-10 Miss's Homes</u> | | e. STREET ADDRESS <u>615 Chestnut Avenue</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>William Henry Moore</u> | | 4. DATE OF DEATH Month Day Year <u>9 - 1 - 1967</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-20-88</u> |
| 9. AGE (In years last birthday) <u>74 1/2 yrs</u> | | 10. IF UNDER 1 YEAR Months Days Hours Min <u>7 1 1 35</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Security Analyst</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Vicksburg, Miss.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Samuel H. Moore</u> | | 14. MOTHER'S MAIDEN NAME <u>Henrietta W. Moore</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO <u>710-09-6666</u> | |
| 17. INFORMANT <u>Deceased in attack</u> | | Address <u>615 Chestnut Ave</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Myocardial Infarction</u> DUE TO (b) <u>Carcinoma Parathyroid Gland with metastases</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>hrs</u> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Radical Neck Surgery</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 18</u> , 1967, to <u>August 1</u> , 1967, that (I) (we) lost saw the deceased alive on <u>Aug. 1</u> , 1967, and that death occurred at <u>255 P.M.</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Newland E. Day</u> | | 22b. DATE SIGNED <u>August 2, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Newland E. Day M.D.</u> | | 22d. ADDRESS <u>4 E 33rd St Baltimore Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>Aug 4, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u> | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u> |
| 24. FUNERAL DIRECTOR <u>Wm Cork-Beeks Towson Md</u> | | 25a. REC'D BY REGISTRAR <u>Aug 4 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>James Judge</u> | | | |

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|---|---|--|---|--|---|-------|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 10694 | | | | | | | | | |
| 10605 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | | c. LENGTH OF STAY IN 1b <u>20 days</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | | | J 3 1 |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u> | | | | | d. STREET ADDRESS <u>707 Chumleigh Road</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>J. Huff Morrison</u> | | | 4. DATE OF DEATH Month Day Year <u>August 13 1967</u> | | | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>Coz</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1-28-13</u> | | 9. AGE (in years last birthday) <u>54</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Sutton West Virginia</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>W. Fletcher Morrison</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>NINA HUFF</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> | | | 16. SOCIAL SECURITY NO. <u>WW II 236-14-4965</u> | | 17. INFORMANT <u>MRS. ESTHER F. MORRISON</u> | | | Address <u>SAME</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> <u>15 min</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Carcinoma of head of pancreas</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Ascites 2° to 15b.</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (a) (this hospital) attended the deceased from <u>25 July</u> , 1967, to <u>13 Aug</u> , 1967, that (b) (we) last saw the deceased alive on <u>13 Aug</u> , 1967, and that death occurred at <u>11:22 PM</u> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>James Lawrence, III</u> | | | | M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <u>13 Aug 67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>JAMES LAWRENCE, III</u> | | | | 22d. ADDRESS <u>GREATER BALTO. MEDICAL CENTER</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>8-15-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u> | | | 23d. LOCATION (City, town or county) (State) <u>Pikesville Md</u> | | |
| 24. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home, Inc.</u> | | | | ADDRESS <u>6500 York Rd. 21212</u> | | 25a. REC'D BY REGISTRAR <u>AUG 15 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10693

10693

| | | | |
|---|------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville | |
| c. LENGTH OF STAY IN 1b years | | d. STREET ADDRESS 113 Hedgewood Road | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 113 Hedgewood Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ROBERT HOLMES MUELLER | | 4. DATE OF DEATH August 26, 19 67 | |
| 5. SEX Male | 6. COLOR OR RACE Cau. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 9, 1923 |
| 9. AGE (In years lost b. r. day) 44 yrs | | 10. IF UNDER 1 YEAR: Months 44 Days 44 Hours 44 Min 44 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Room Supervisor | | 10b. KIND OF BUSINESS OR INDUSTRY A. A. I. | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Herbert Mueller, Sr. | | 14. MOTHER'S MAIDEN NAME Irene Amelia Cook | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO 219-18-6923 | |
| 17. INFORMANT Mrs. Doris J. Mueller, Same as # 2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY 201X IMMEDIATE CAUSE (a) Hodgkins Disease DUE TO (b) 201X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) 201X | | INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs | |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from Jan 19, 1962 , to Aug 26, 1967 that (I) (we) last saw the deceased alive on Aug 26, 1967 , and that death occurred at 8:45 AM , from 6 causes and on the date stated above. | | | |
| 22a. SIGNATURE Charles Herbert Mueller, Jr. | | 22b. DATE SIGNED August 26, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) C. Herbert Mueller, Jr. | | 22d. ADDRESS Parkton, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Aug. 29, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | 23d. LOCATION (City or Town) (County) (State) Woodlawn, Maryland | |
| 24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204 | | 25a. REC'D BY REGISTRAR AUG 29 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

| <div>10696</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>Item #2 FilmG392 8/24/67</div> <div>CERTIFICATE OF DEATH</div> <div>20697</div> | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN TB <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RIDGEWAY MANOR CONV. HOME</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE (Baltimore)</u> d. STREET ADDRESS <u>4321 Joppa Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>SAMUEL</u> First Middle Last 4. DATE OF DEATH <u>AUG. 18 1967</u> Day Year | | | | 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>7-25-1892</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u> | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHOE REPAIR</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | | | | 11. BIRTHPLACE (County & State, or foreign country) <u>ITALY</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>? MUFFOLETTO</u> | | | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WWI</u> | | | | 16. SOCIAL SECURITY NO. <u>217-38-6018</u> | | | |
| 17. INFORMANT <u>DANIEL MUFFOLETTO</u> | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. (c) <u> </u> | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | | | 20f. (City or town) (County) (State) <u> </u> | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1 am</u> <u>1967</u> to <u>18 Aug</u> <u>1967</u> that (I) (we) last saw the deceased alive on <u>18 Aug</u> <u>1967</u> and that death occurred at <u>2:30 P</u> <u>M</u> from the causes and on the date stated above. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>William Goodman</u> | | | | 22b. DATE SIGNED <u>Aug 67</u> | | | | 22c. PHYSICIAN'S NAME (Type) <u>WILLIAM GOODMAN, MD</u> | | | | 22d. ADDRESS <u>1334 Audubon Ave - 21227</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | 23b. DATE THEREOF <u>8-22-1967</u> | | | | 23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEM.</u> | | | | 23d. LOCATION (City, town or county) (State) <u>BALTO. MARYLAND</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Edward J. Weber</u> | | | | 25a. REC'D BY REGISTRAR <u> </u> | | | | 25b. REGISTRAR'S SIGNATURE <u> </u> | | | | 25c. DATE <u>AUG 21 1967</u> | | | |

10697

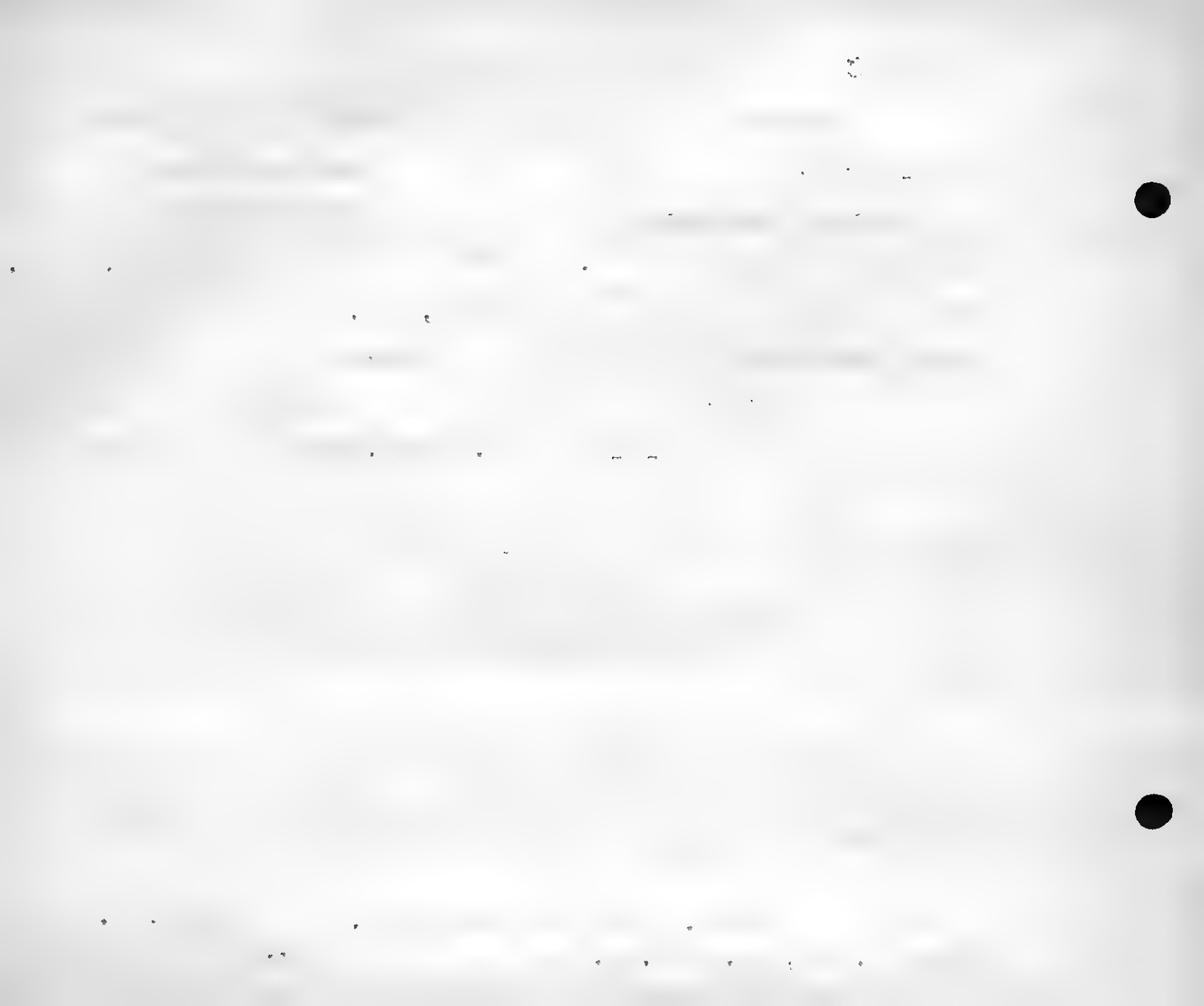
CERTIFICATE OF DEATH

10638

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Baltimore c. LENGTH OF STAY IN TB Baltimore 21212 | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212 d. STREET ADDRESS 6689 Loch Hill Road | |
| 3. NAME OF DECEASED (Type or print) PAUL C. MUGGE | | 4. DATE OF DEATH Month August Day 27 Year 1967 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 7, 1882. |
| 9. AGE (In years last birthday) yrs. 85 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Sea Captain | |
| 11. BIRTHPLACE (County & State, or foreign country) Holland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO 090-16-0042 | |
| 17. INFORMANT Mrs. Anita K. Barnes | | Address (Same) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - ASCVD DUE TO (b) - myocardial infarct DUE TO (c) - pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 8-24 , 19 67 , to 8-27 , 19 67 , that (I) (we) last saw the deceased alive on 8-26 , 19 67 , and that death occurred at 8:27 AM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Alan Tapper MD | | 22b. DATE SIGNED 8/28/67 | |
| 22c. PHYSICIAN'S NAME (Type) ALAN TAPPER | | 22d. ADDRESS 7501 York Rd | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/30/67. | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Cem. | 23d. LOCATION (City or Town) (County) (State) Elkridge, Md. |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | 25a. REC'D BY REGISTRAR AUG 28 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Coroner papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10698

CERTIFICATE OF DEATH

10699

| | | | |
|---|---|---|--|
| 1 PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KINGSVILLE</u> | | c. LENGTH OF STAY IN lb | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BEL AIR RD BOX 686</u> | | d STREET ADDRESS <u>WHITE MARSH</u> | |
| 3. NAME OF DECEASED (Type or print) <u>HELEN M. MULLEN</u> | | 4. DATE OF DEATH Month <u>AUG</u> Day <u>11</u> Year <u>1967</u> | |
| 5 SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH <u>AUG. 15, 1895</u> 71 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (County & State, or foreign country) <u>MD.</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>CHARLES STANBURY</u> | | 14. MOTHER'S MAIDEN NAME <u>SARAH HEPDING</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNK</u> | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT <u>MRS ARTHUR SCHULTZ</u> | | Address <u>BOX 686 KINGSVILLE</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary asphyxia</u> DUE TO (b) <u>Ac. Pulmonary edema</u> DUE TO (c) <u>Atherosclerotic heart dis.</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. 15 min.</u> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Asphyxia; Embolism</u> | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>52</u> , to <u>8/11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/10</u> 19 <u>67</u> , and that death occurred at <u>7:00</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | 22b. DATE SIGNED <u>8/12/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>J. BLATT M.D.</u> | | 22d. ADDRESS <u>East, md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>8/14/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u> | 23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD.</u> |
| 24 FUNERAL DIRECTOR <u>J.G. CONNELLY SONS</u> | | 25a. REC'D BY REGISTRAR DATE <u>AUG 16 1967</u> | |
| ADDRESS <u>300 MACE</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10698

CERTIFICATE OF DEATH

10700

| | | | |
|---|----------------------------------|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor Nursing Home | | d. STREET ADDRESS 3101 Weaver Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Mary Middle H. Last Naeny | | 4 DATE OF DEATH Month Aug. Day 21 Year 19 67 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Feb. 26, 1881. |
| 9 AGE (In years last birthday) 86 yrs | | IF UNDER 1 Year Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (County & State, or foreign country) Virginia | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13 FATHER'S NAME Alexander Hall | | 14. MOTHER'S MAIDEN NAME Florida ? | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-144-5355 | |
| 17 INFORMANT Mr. Albert H. Hall, 5203 Falls Rd. Balto. Md. | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach - metastases DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH 1 yr. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from August 18, 1967 to August 21, 1967 , that (I) (we) last saw the deceased alive on August 18, 1967 , and that death occurred at 11:45 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE A. Allan Spier | | 22b. DATE SIGNED 8/21/67 | |
| 22c. PHYSICIAN'S NAME (Type) A. Allan Spier | | 22d. ADDRESS Baltimore, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/24/67. | |
| 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | |
| 24 FUNERAL DIRECTOR Leonard J. Rack, Inc. Balto. Md. 21214 | | 25a REC'D BY REGISTRAR DATE AUG 22 1967 | |
| 25b REGISTRAR'S SIGNATURE J. Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

10700

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 10701

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WOOD-LAWN</u> | | | | c. LENGTH OF STAY IN 1b <u>20 YEARS</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1748 GORDON AVE.</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | d. STREET ADDRESS <u>284 N. B. LOVER ST</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>CATHERINE</u> Last <u>NAUMANN</u> | | | | 4. DATE OF DEATH Month <u>8</u> Day <u>19</u> Year <u>1968</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>JUNE 7, 1882</u> | |
| 9. AGE (In years last birthday) <u>85</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>8</u> Days <u>19</u> | | 11. IF UNDER 24 HRS. Hours <u>19</u> Min. <u>00</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u> | | | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>PITTSBURG, PA.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>HENRY HOTEM</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARGARET WAYMAN</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>220-54-5909</u> | | | |
| 17. INFORMANT <u>DAUGHTER</u> <u>MRS. ANGELA GARRIST</u> | | | | Address <u>BALTO. 2127 MO</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL APOPLEXY</u> DUE TO (b) <u>HYPERTENSION</u> DUE TO (c) <u>15 YEARS</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 YEARS</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>OCT 15, 1950</u> to <u>AUGUST 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>AUGUST 18, 1967</u> , and that death occurred at <u>8:19</u> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Edwin L. Pierpont</u> | | | | 22b. DATE SIGNED <u>8/19/67</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u> | | | | 22d. ADDRESS <u>8204 LIBERTY RD - BALTO. 21207 MD.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | 23b. DATE THEREOF <u>8-22-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN Cem.</u> | |
| 23d. LOCATION (City, town or county) (State) <u>BALTO., MD.</u> | | | | 23e. REC'D BY REGISTRAR <u>AUG 22 1967</u> | | | |
| 23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | 23g. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 77 hours after death.

VR A15 (4)
15M 9/

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 10701 | | | | | | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Balto. | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto. | | | | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown | | | | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 185 | | | | | d. STREET ADDRESS Box 185 | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Andrew Jackson Naylor | | | | | 4. DATE OF DEATH Aug. 27, 19 67 | | | | | | | | | | | | | | |
| 5. SEX Male | | | | | 6. COLOR OR RACE White | | | | | | | | | | | | | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 8. DATE OF BIRTH Oct. 25, 1887 | | | | | | | | | | | | | | |
| 9. AGE (In years last birthday) 79 yrs. | | | | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man | | | | | 10b. KIND OF BUSINESS OR INDUSTRY State Road | | | | | | | | | | | | | | |
| 11. BIRTHPLACE (County & State, or foreign country) Balto. Co. Md. | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | | | | | | |
| 13. FATHER'S NAME Thomas L. Naylor | | | | | 14. MOTHER'S MAIDEN NAME Elizabeth A. Curtis | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | | | 16. SOCIAL SECURITY NO. 213-12-2917 | | | | | | | | | | | | | | |
| 17. INFORMANT Mrs. Ada M. Naylor | | | | | Address Box 185 Reisterstown, Md. | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary (Carcinoma of Colon) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | | | | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | | | 20f. (City or town) (County) (State) | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov. 29, 1966 to Aug. 27, 1967 , that (I) (we) last saw the deceased alive on 5/24 1967 , and that death occurred at 1:00 P.M. , from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE Joseph E. Bush | | | | | | | | | | 22b. DATE SIGNED 8/28/67 | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) Joseph E. Bush, M.D. | | | | | | | | | | 22d. ADDRESS Hampstead, Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | 23b. DATE THEREOF Aug. 30, 1967 | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery | | | | | | | | | | 23d. LOCATION (City, town or county) (State) Upperco, Balto. Co. Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Tipton - Eline Funeral Home | | | | | | | | | | 25a. REC'D BY REGISTRAR AUG 30 1967 | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10702

CERTIFICATE OF DEATH

10703

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills | | c. LENGTH OF STAY IN 1b 5 months | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital | | d. STREET ADDRESS 3600 West Belvedere Ave. | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Marcellus - NELSON | | 4. DATE OF DEATH Month Day Year 8 16 19 67 | |
| 5 SEX Male | 6. COLOR OR RACE Negro | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 6-22-66 |
| 9 AGE (In years last birthday) yrs 1 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent | |
| 10b KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore Cty, Md. | |
| 12 CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Raymond Read | |
| 14. MOTHER'S MAIDEN NAME Barbara Jackson | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no -- | |
| 16 SOCIAL SECURITY NO none | | 17. INFORMANT Address Rosewood Records, Owings Mills, Maryland | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH 14 mo |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21 I certify that (X) (this hospital) attended the deceased from 3/6 , 19 67 , to 8/16 , 19 67 , that (X) (we) last saw the deceased alive on 8/16 , 19 67 , and that death occurred at 3:30 A.M., from causes and on the date stated above | | | |
| 22a. SIGNATURE Philip Zieve | | 22b. DATE SIGNED 8/16/67 | |
| 22c. PHYSICIAN'S NAME (Type) Philip Zieve, M.D. | | 22d. ADDRESS Rosewood St. Hosp., Owings Mills, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF 8/17/67 | 23c. NAME OF CEMETERY OR CREMATORY Johns Hopkins School of Med. | 23d. LOCATION (City or Town) (County) (State) 709 N. Wolfe, Balto. Md. |
| 24 FUNERAL DIRECTOR Newell Funeral Home, Baltimore - 8-1114 | | 25a REC'D BY REGISTRAR AUG 16 1967 | |
| | | 25b REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10703

CERTIFICATE OF DEATH

10704

| | | | | | | | | |
|--|--|--------------------------------------|---|---|--|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore Shady Nook Nursing Home MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Baltimore Co. | | | c. LENGTH OF STAY IN 1b | | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shady Nook Nursing Home | | | | d. STREET ADDRESS 5549 Oregon Ave. | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) WILLIAM L. NETHKEN | | | | 4 DATE OF DEATH Month August Day 25 Year 1967 | | | | |
| 5 SEX Male | | 6 COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 15, 1879 | | |
| | | | | 9 AGE (In years last birthday) yrs. 88 | | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Supervisor | | | 10b KIND OF BUSINESS OR INDUSTRY B & O RR | | 11 BIRTHPLACE (County & State, or foreign country) Oakland, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles O. Nethken | | | | 14 MOTHER'S MAIDEN NAME Ada Best | | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16 SOCIAL SECURITY NO 705-07-4943A | | 17 INFORMANT Miss Carrie H. Nethken, 5549 Oregon Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Failure DUE TO (b) Arterio Sclerotic Cardiovascular Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from July , 19 67 , to 8/25 , 19 67 , that (I) (we) last saw the deceased alive on 8/25 , 19 67 , and that death occurred at 9:12 AM , from causes and on the date stated above. | | | | | | | | |
| 22a SIGNATURE J. N. Frederick MD | | | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b DATE SIGNED 8/25/67 | | |
| 22c. PHYSICIAN'S NAME (Type) J. N. Frederick MD | | | | 22d. ADDRESS 1311 Francis Ave 21227 | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b DATE THEREOF 8-28-1967 | | 23c NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery | | 23d LOCATION (City or Town) (County) (State) Howard County, Maryland | | |
| 24 FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. | | | | 25a REC'D BY REGISTRAR DATE AUG 28 1967 | | 25b REGISTRAR'S SIGNATURE Charles Judge | | |

MEDICAL CERTIFICATION

10704

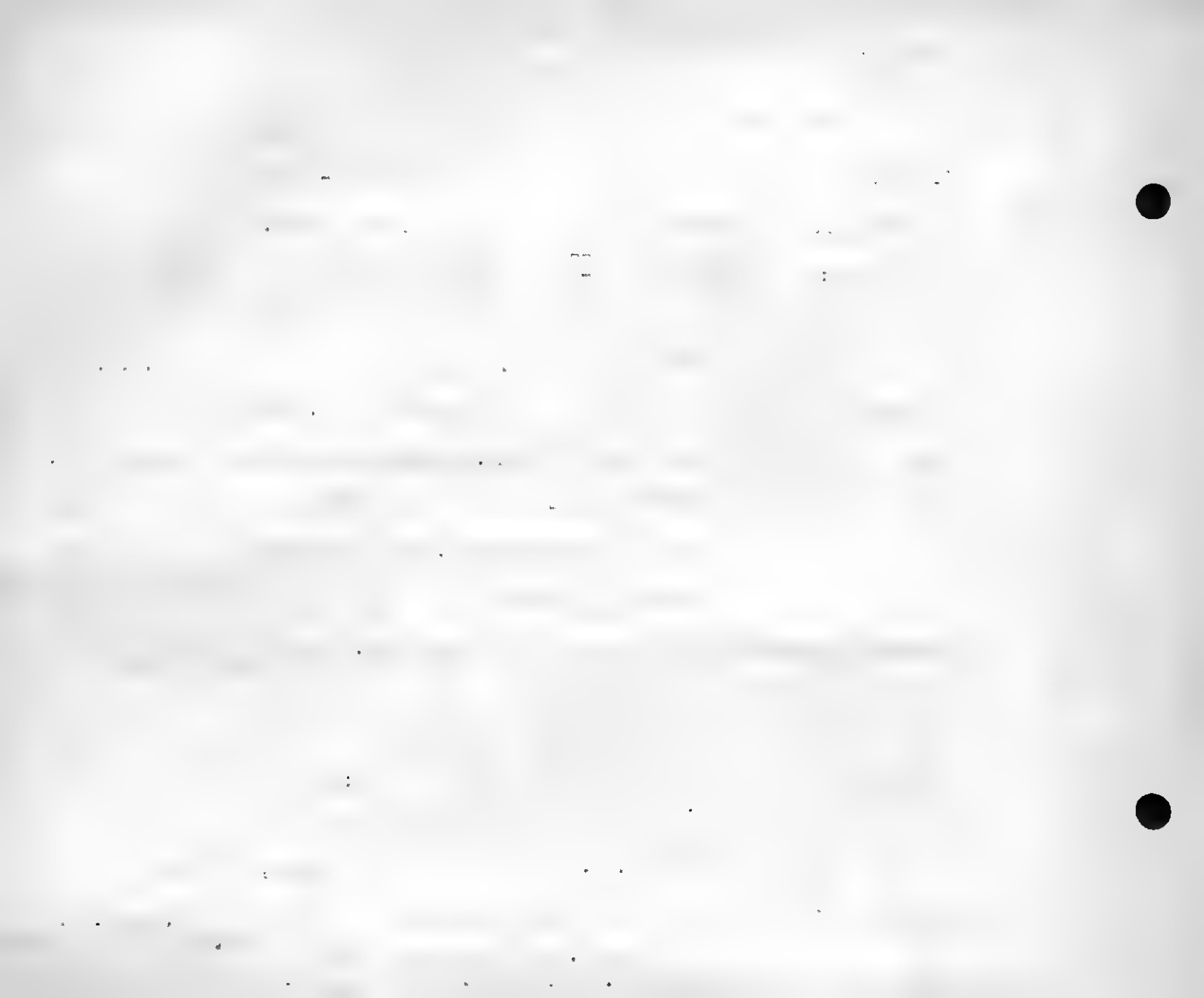
CERTIFICATE OF DEATH

10705

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN 1b 11 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) MICHAEL Middle --- Last NIKONCHUK NICHOLS | | 4. DATE OF DEATH Month AUGUST Day 7 Year 1967 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 8/27/05 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10b. KIND OF BUSINESS OR INDUSTRY GAS & ELECTRIC CO. | 11. BIRTHPLACE (County & State, or foreign country) POLAND |
| 13. FATHER'S NAME UNKNOWN | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I | | 16. SOCIAL SECURITY NO. 212 05 45 85 | |
| 17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STAPHYLOCOCCAL PNEUMONIA, BILATERAL. DUE TO (b) STAPHYLOCOCCAL ABSCESS, PRE SACRAL AREA. DUE TO (c) LYMPHOMA (HODGKINS). | | | INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 3 DAYS ? |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CEREBRAL ARTERIOSCLEROSIS; CHRONIC PYELONEPHRITIS; ADRENAL CORTICAL | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II) STEROID THERAPY. | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that he (this hospital) attended the deceased from 7/27/67 , 19__ to 8/7/67 , 19__, that it (we) last saw the deceased alive on 8/7/67 , 19__, and that death occurred at 4:10AM , from causes and on the date stated above | | | |
| 22a. SIGNATURE <i>Neilson Neilson</i> | | 22b. DATE SIGNED 8/7/67 | |
| 22c. PHYSICIAN'S NAME (Type) NEILON NEILSON, M. D. | | 22d. ADDRESS VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF AUG 10, 1967 | 23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY | 23d. LOCATION (City or Town) (County) (State) GERMAN HILL RD. BALTO. MD |
| 24. FUNERAL DIRECTOR Joseph N. Zannino Funeral Home | | 25a. REC'D BY 8 | |
| 25b. DATE 257 S. Conkling St. Baltimore, Md. | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---------------------------|--|---|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ARBUTUS c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1247 LEEDS TERRACE | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ARBUTUS d. STREET ADDRESS 1247 LEEDS TERRACE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First NINA Middle MAY Last NOLAN | | | | | | 4. DATE OF DEATH Month AUG. Day 10 Year 1967 | | | | | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH DEC. 19, 1890 | | 9. AGE (In years last birthday) 76 yrs. | | 10. FUNDER 1 YEAR <input type="checkbox"/> FUNDER 24 HRS. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk | | | | 10b. KIND OF BUSINESS OR INDUSTRY Dept Store | | 11. BIRTHPLACE (County & State, or foreign country) New York | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME William W. Adams | | | | | | 14. MOTHER'S MAIDEN NAME Minnie | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. 219-30-5590 | | 17. INFORMANT Mr Helen Tynnell - 1247 Leeds Terrace | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOPATHY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHLORIDE DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 54 HRS | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 21. I certify that (I) (this hospital) attended the deceased from 1950 to 8/10 , 19 67 , that (I) (we) last saw the deceased alive on 8/11 19 67 , and that death occurred at 6AM , from the causes and on the date stated above. | | | | 22a. SIGNATURE Phyllis E. [Signature] | | | |
| 22b. DATE SIGNED 8/11/67 | | | | 22c. PHYSICIAN'S NAME (Type) Phyllis E. [Signature] | | | | 22d. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 8-14-67 | | 23c. NAME OF CEMETERY OR CREMATORY Cathedral Cem. | | | 23d. LOCATION (City, town, or county) (State) Baltimore Md. | | |
| 24. FUNERAL DIRECTOR Farley Cronan | | | | ADDRESS 701 E. Catoctinville, Md. | | | | 25a. REC'D BY REGISTRAR AUG 15 1967 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10706

CERTIFICATE OF DEATH

10707

| | | | |
|--|---------------------------------|---|---|
| 1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OWINGS MILLS c. LENGTH OF STAY IN lb OWINGS MILLS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BAPTIST HOME OF MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY A c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 8606 SUMMITT AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) MAE FREDRICKA NORRIS | | 4 DATE OF DEATH Month Day Year AUGUST 2 19 67 | |
| 5 SEX FEMALE | 6 COLOR OR RACE WHITE | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH NOV. 13, 1883 |
| 9 AGE (In years last birthday) 83 | | 10 IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY HOME | |
| 11 BIRTHPLACE (County & State or foreign country) BALTIMORE, MARYLAND | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME FREDERICK KORN | | 14. MOTHER'S MAIDEN NAME CHRISTINA JUDD | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT BAPTIST HOME OF MD. OWINGS MILLS, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Sclerosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Arteriosclerotic Cardiovascular Disease (b) DUE TO (c) Vascular Disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Aug 2, 1967 to Aug 2, 1967 , that (I) (we) last saw the deceased alive on Aug 2, 1967 , and that death occurred at 4:10 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE DR. M. PAUL BYERLY | | 22b. DATE SIGNED 8/7/67 | |
| 22c. PHYSICIAN'S NAME (Type) DR. M. PAUL BYERLY | | 22d. ADDRESS 5820 YORK RD, BALTIMORE, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 8-5-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK | | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD. | |
| 24. FUNERAL DIRECTOR MITCHELL-WIEDEFELD HOME, INC. | | 25a. REC'D BY REGISTRAR AUG 7 1967 | |
| ADDRESS 6500 YORK RD. | | 25b. REGISTRAR'S SIGNATURE J. Charles Jones | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

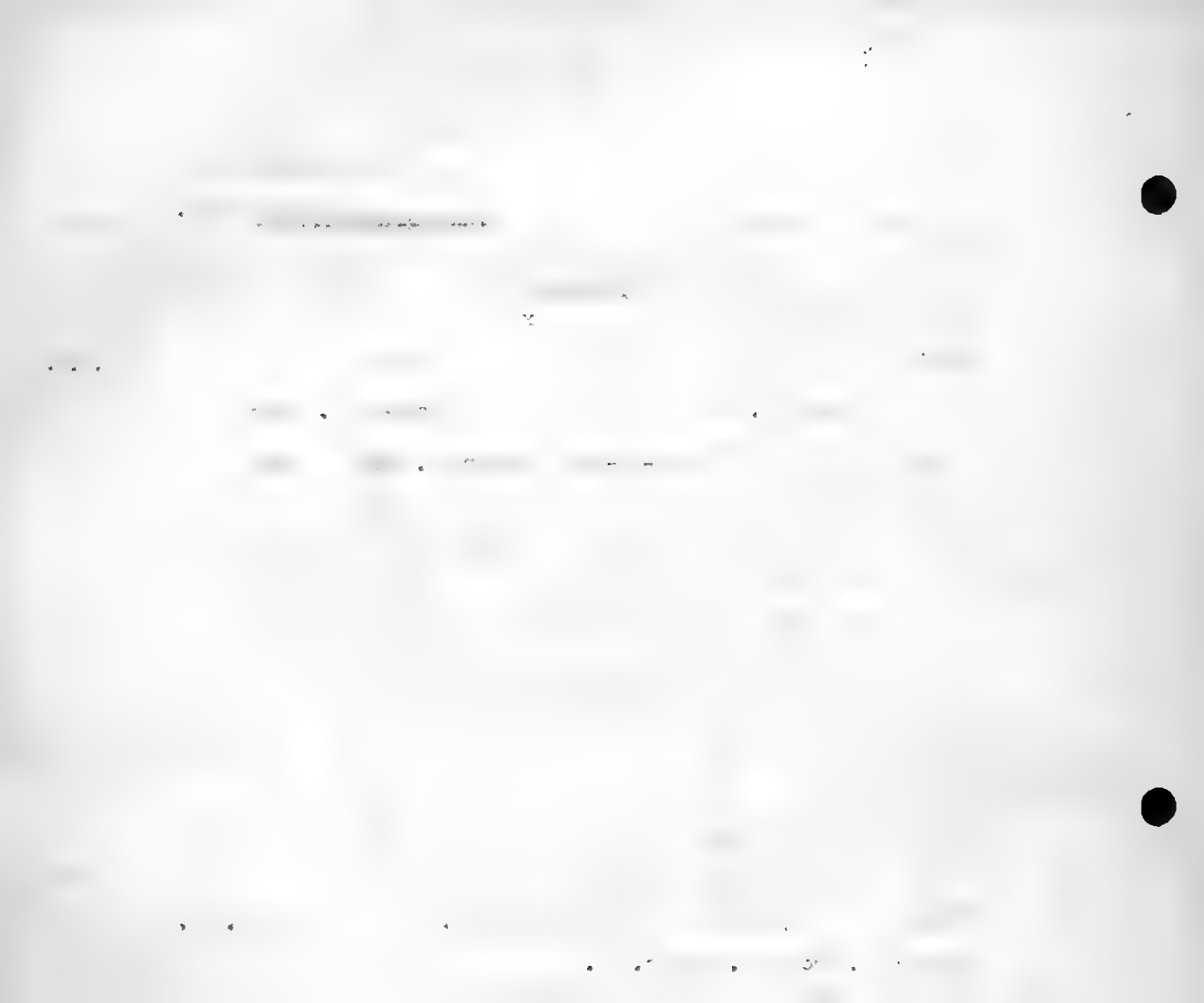
10707

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10708

| | | | |
|--|------------------------------------|---|---|
| 1 PLACE OF DEATH a COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b COUNTY | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN 1b Baltimore 22001 21212 | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | d STREET ADDRESS 521 Rossiter Ave. 22001 21212 | |
| 3. NAME OF DECEASED (Type or print) First Middle Last William Robert NULL | | 4 DATE OF DEATH Month Day Year August 24, 19 67 | |
| 5. SEX Male | 6 COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> XXXXXXXXXX WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8 DATE OF BIRTH July 5, 1943 |
| 9 AGE (in years last birthday) 24 yrs | | 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist | |
| 10b KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Robert C. Null | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes | | 16 SOCIAL SECURITY NO 214-04-3056 | |
| 17 INFORMANT Robert C. Null | | Address same | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO (b) DUE TO (c) Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost | | INTERVAL BETWEEN ONSET AND DEATH 37 Hrs | |
| PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Thrown to Road from Front RT Seat of Volkswagen | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. August 22 1967 | | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office, b.d.g., etc.) Street | | 20f (City or town) (County) (State) Towson #4 Md | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles F. O'Donnell, M.D. | | 22 DATE SIGNED 8/24/67 | |
| EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county) | |
| 23a BURIAL, CREMATION, or other disposition (Specify) Burial | 23b DATE THEREOF 8/28/67 | 23c NAME OF CEMETERY OR CREMATORY Druid Ridge Cem. | 23d LOCATION (City or Town) (County) (State) Balto, Md. |
| 24 FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto, Md. | | 25a REC'D BY REGISTRAR AUG 25 1967 | |
| | | 25b REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

220

10708

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10709

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 16 21214 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2702 Bayonne Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Perry V. OGLE | | | | 4 DATE OF DEATH Month Day Year August 2, 1967 | | | |
| 5 SEX Male | | 6 COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 24, 1892 | |
| 9 AGE (In years lost birthday) 75 yrs. | | 10. IF UNDER 1 YEAR Months Days 75 | | 11. IF UNDER 24 HRS Hours Min 75 | | 12. IF UNDER 24 HRS Hours Min 75 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter Foreman | | | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME Samuel V. Ogle | | | |
| 14. MOTHER'S MAIDEN NAME Unknown | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 215-07-7646 | | | | 17. INFORMANT Mrs. Olive R. Ogle Address (Same) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7/28/ , 19 67 , to 8/2/ , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/2/ , 19 67 , and that death occurred at 8 A.M. , from causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE <i>Beatriz P. Dizon</i> 22c. PHYSICIAN'S NAME (Type) Beatriz P. Dizon, M.D. | | | | 22b. DATE SIGNED August 1, 1967 22d. ADDRESS 7620 York Rd., Towson, Md. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/5/67. | | 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cem. | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | |
| 24. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | 25a. REC'D BY REGISTRAR DATE AUG 2 1967 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10709

10710

| | | | |
|---|---|---|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson c. LENGTH OF STAY IN TB 12 days | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD. b. COUNTY BALTIMORE CITY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital | | d. STREET ADDRESS 2813 BEECHLAND AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) MISS. CHARLOTTE First Middle Last | | 4 DATE OF DEATH AUG. 1, 1967 Month Day Year | |
| 5 SEX F | 6 COLOR OR RACE W | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 5-7-1881 9 AGE (In years last birthday) 86 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (County & State or foreign country) GERMANY | | 12 CITIZEN OF WHAT COUNTRY? U S A | |
| 13 FATHER'S NAME JOHN PALM | | 14. MOTHER'S MAIDEN NAME MARGARENE SPANIOL | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-54-1881 | |
| 17 INFORMANT Records, Mt. Wilson State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: IMMEDIATE CAUSE (a) 0021 Diffuse pulmonary fibrosis DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH 2 years | |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchiectasis, tuberculosis | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 1B) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21 I certify that (I) (this hospital) attended the deceased from 7-19, 1967 , to 8-1, 1967 that (I) (we) last saw the deceased alive on 8-1, 1967 , and that death occurred at 2:15 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE W. Newcomer | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Supt. | | 22d. ADDRESS Mt. Wilson State Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8 4 1967 | 23c. NAME OF CEMETERY OR CREMATORY Holy Cross | 23d. LOCATION (City or town) (County) (State) Brooklyn, A. A. CO. Md. |
| 24. FUNERAL DIRECTOR Mc Gully | | 25a. REC'D BY REG STRAR 130 E. Fort Ave DATE AUG 3 1967 | |
| | | 25b. REG STRAR'S SIGNATURE J. Charles Jones | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

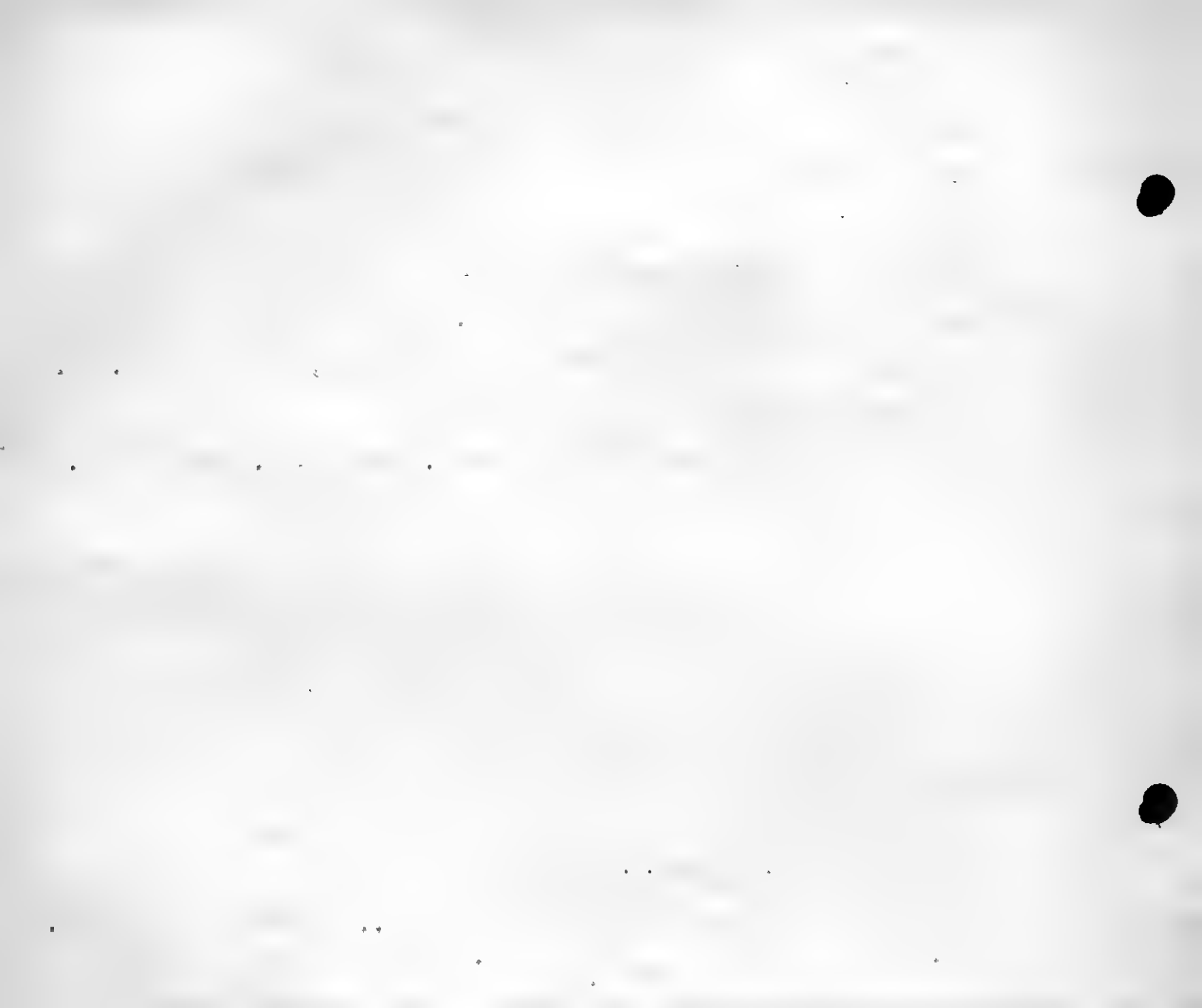
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10710

10711

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Towson | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St/ Joseph's Hospital | | | | e. STREET ADDRESS 3802 Kimble Road | | | |
| 3. NAME OF DECEASED (Type or print) LILLIAN Marion PANUSKA | | | | 4. DATE OF DEATH Month August Day 13 Year 1967 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 8, 1900 | |
| 9. AGE (In years last birthday) 66 yrs | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Cleveland, Ohio | |
| 13. FATHER'S NAME Joseph Chadema | | | | 14. MOTHER'S MAIDEN NAME Mary | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | | 16. SOCIAL SECURITY NO 295-03-6151 | | | |
| 17. INFORMANT Frank J. Panuska, Jr. | | | | Address Whiteford, Md. Deep Run Rd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Driver of auto that went through a stop sign | | | |
| 20c. TIME OF INJURY Month Day Year 5:50 pm 8 13 19 67 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Highway | | | | 20f. (City or town) (County) (State) Baltimore, Md. | | | |
| 21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Werner U. Spitz EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D. | | | | 22. DATE SIGNED 8-14-67 | | | |
| 23a. BURLA, CREMATION REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 8/16/1967 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Belair Memorial Grds. | | | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | | | 25a. REC'D BY REGISTRAR AUG 16 1967 | | | |
| ADDRESS 4905 York Rd. Balto. 12, Md. | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

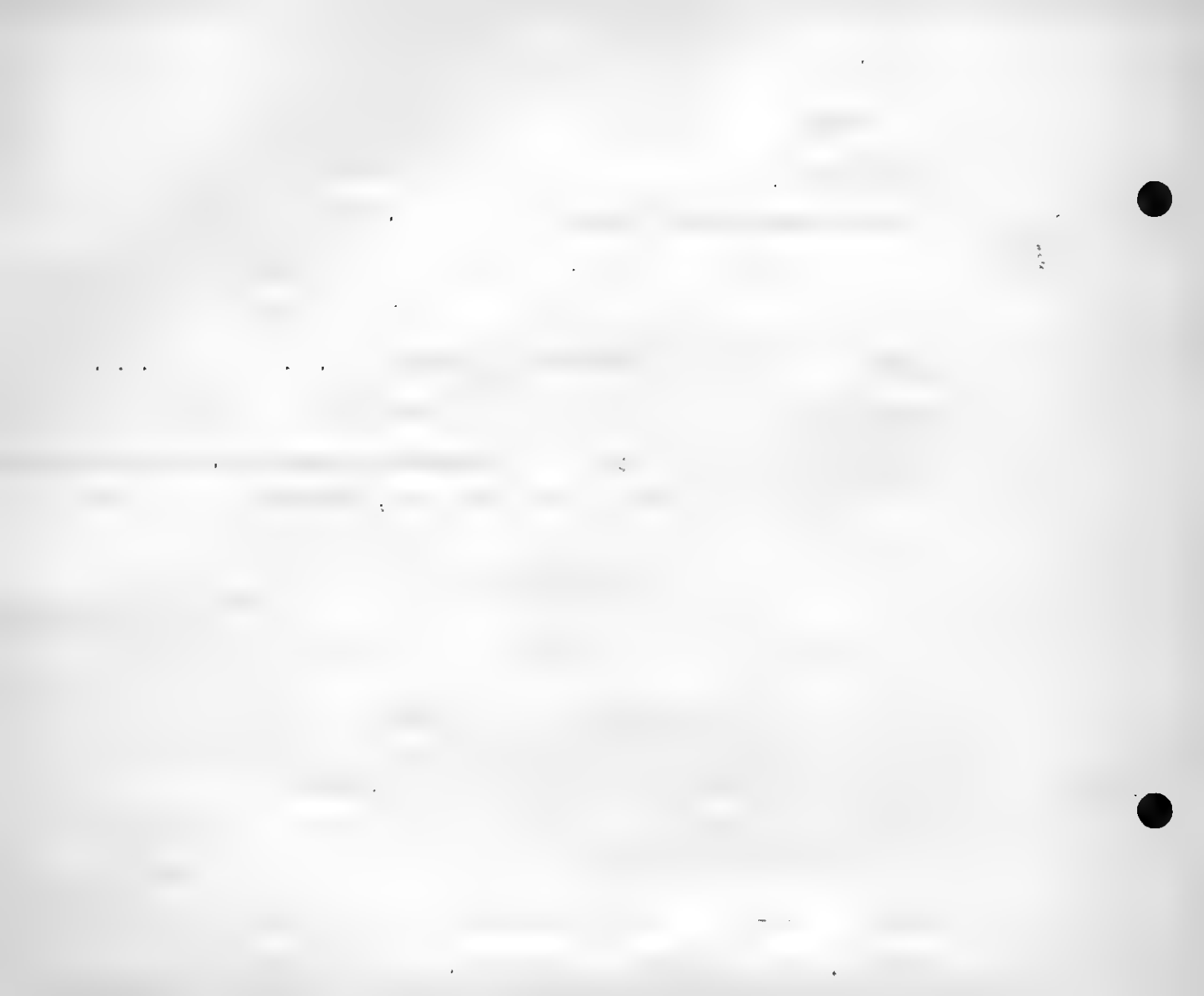
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10711

CERTIFICATE OF DEATH

10712

| | | | | | |
|---|---|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD, | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | | d. STREET ADDRESS 629 N. SCHROEDER STREET | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH DANIEL PARKER | | | 4. DATE OF DEATH Month Day Year AUGUST 2 19 67 | | |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/12/92 | 9. AGE (In years last birthday) yrs 74 | IF UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PORTER | | 10b. KIND OF BUSINESS OR INDUSTRY HOSPITALS | | 11. BIRTHPLACE (County & State, or foreign country) GREENVILLE, N. C. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME NATHAN PARKER | | |
| 14. MOTHER'S MAIDEN NAME SARA VINCENT | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I | | |
| 16. SOCIAL SECURITY NO. 215 05 45 44 | | 17. INFORMANT VA HOSPITAL FORTHOWARD, MD. Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DIVERTICULITIS LEFT COLON, BLEEDING DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) INTERVAL BETWEEN ONSET AND DEATH WEEK | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE GANGRENE RIGHT FOOT | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from JULY 24, 1967 , to AUGUST 2, 1967 , that (I) (we) last saw the deceased alive on AUGUST 2, 1967 , and that death occurred on 11:15 PM from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <i>George Mac Elfrick</i> M.D. | | | 22b. DATE SIGNED AUGUST 3, 1967 | | 22c. PHYSICIAN'S NAME (Type) GEORGE MAC ELFRICK |
| 22d. ADDRESS VAH FORT HOWARD, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 8-7-67 | 23c. NAME OF CEMETERY OR CREMATORY ARBUTUS CEMETERY | 23d. LOCATION (City or Town) (County) (State) ARBUTUS MARYLAND | | |
| 24. FUNERAL DIRECTOR CHARLES R. LAW 802 MADISON AVE BALTO MD. | | | 25a. REC'D BY REGISTRAR AUG 7 4 1967 | 25b. REGISTRAR'S SIGNATURE <i>Charles R. Law</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10712

CERTIFICATE OF DEATH

10713

| | | | | | | | |
|---|----------------------------------|---|---|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3421 Birch Hollow Road</u> | | | | d. STREET ADDRESS <u>3421 Birch Hollow Road</u> #8 | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Eli</u> Middle <u>Jay</u> Last <u>Pateka</u> | | | | 4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1967</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 13, 1952</u> | 9. AGE (in years last birthday) <u>14</u> yrs | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | | 11. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u> | | | 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> | |
| 13. FATHER'S NAME <u>Isadore Pateka</u> | | | 14. MOTHER'S MAIDEN NAME <u>Anna Pfeffer</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO <u>UNKNOWN</u> | | 17. INFORMANT <u>Mr. Isadore Pateka, 3421 Birch Hollow Road</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Embolus</u> 1540 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe congenital cardiac disease (Aortic Stenosis)</u> (c) <u>Sudden death</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u> </u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 13, 1967</u> to <u>Aug. 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 13, 1967</u> , and that death occurred at <u>5:00 P.M.</u> from causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE <u>Samuel S. Shick</u> M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>Aug 7/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Samuel Shickley Glick</u> | | | | 22d. ADDRESS <u>3914 Park Heights Avenue</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>8/7/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Chizuk Amuno (Belington)</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u> | | | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS 15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #8, 9 & 12 only

10713

CERTIFICATE OF DEATH

20714

| | | | |
|--|---|---|--|
| 1 PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>A.C.</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Blackburn Park</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home - 5466 Whitlock Road</u> | | d. STREET ADDRESS <u>108 W. 11th Ave.</u> | |
| 3 NAME OF DECEASED (Type or print) <u>KATHERINE K. PATRICK (PETRYK)</u> | | 4 DATE OF DEATH Month <u>Aug.</u> Day <u>21</u> Year <u>1967</u> | |
| 5 SEX <u>F</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 18, 1897</u> |
| 9. AGE (In years last birthday) <u>70</u> yrs | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | |
| 11 BIRTHPLACE (County & State, or foreign country) <u>AUSTRIA-HUNGARY</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13 FATHER'S NAME <u>V. KONDRUSKA</u> | | 14. MOTHER'S MAIDEN NAME <u>D.</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO <u>217-14-1313</u> | |
| 17 INFORMANT <u>Fam. / 1 -</u> | | Address <u>Same</u> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD - severe.</u> DUE TO (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u> </u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u> | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u> </u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>A.R. Sosnowski</u> | | 22b. DATE SIGNED <u>8/23/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>A.R. Sosnowski</u> | | 22d ADDRESS <u>4016 Ritchie Hwy Balto. 25. Md</u> | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b DATE THEREOF <u>AUG. 24, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem.</u> | 23d LOCATION (City or Town) (County) (State) <u>Balto. Md. MD</u> |
| 24. FUNERAL DIRECTOR <u>John H. Nelson</u> <u>4200 Pennsylvania Ave</u> <u>Baltimore 21226, Md.</u> | | 25a. REC'D BY REGISTRAR <u>AUG 24 1967</u> | |
| 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

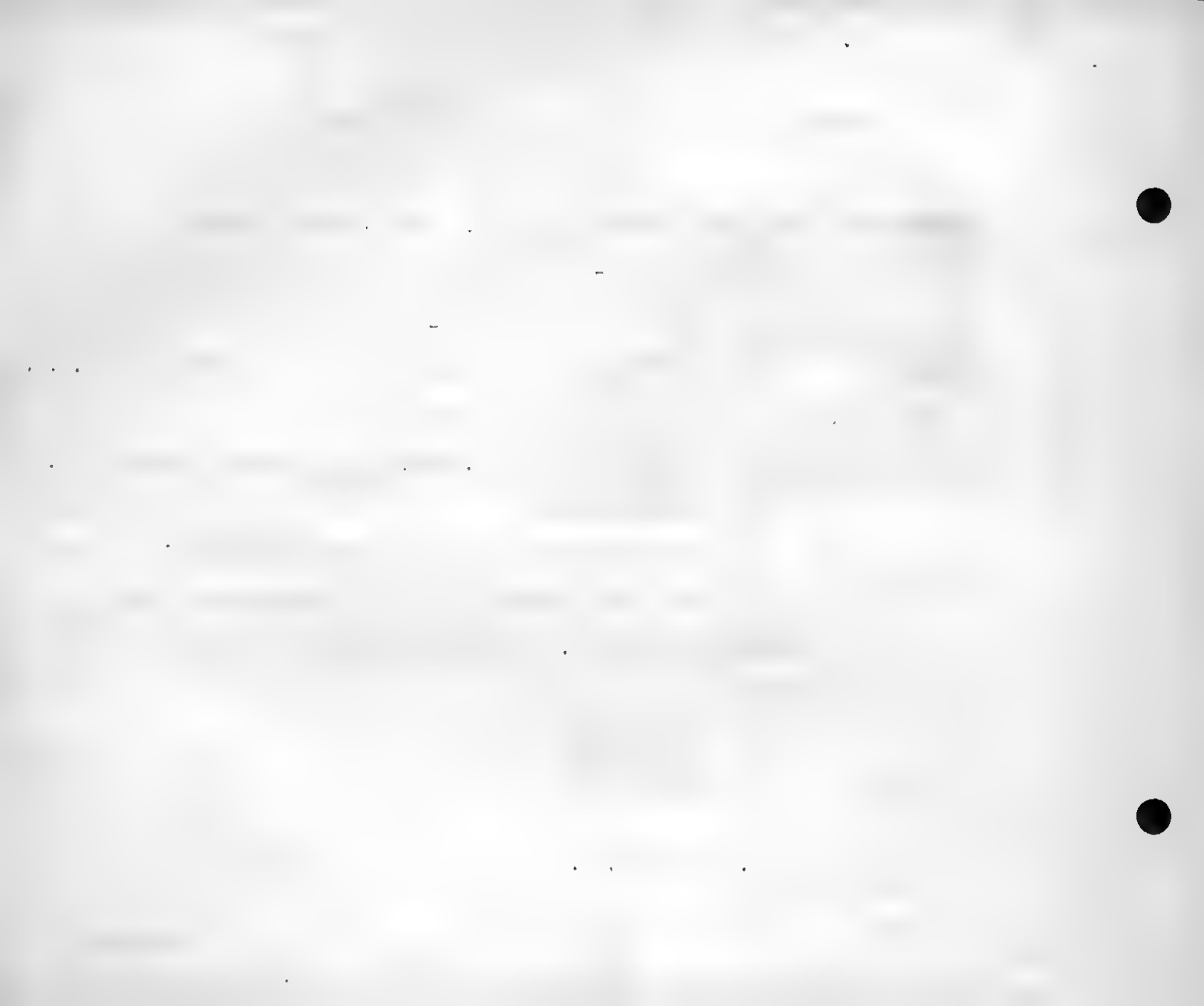
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #8 Film #G392 8/25/67 ph

10714

CERTIFICATE OF DEATH

10715

| | | | | | |
|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN 1b 10 DAYS | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | | | d. STREET ADDRESS 3808 OLD FREDERICK ROAD | |
| 3. NAME OF DECEASED (Type or print) First BENTON Middle - Last PEGRAM | | 4. DATE OF DEATH Month AUGUST Day 20 Year 19 67 | | | |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/17/1907 AGE (In years last birthday) 77 yrs | | IF UNDER 1 Year Months Days IF UNDER 24 HRS Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ORDERLY | | 10b. KIND OF BUSINESS OR INDUSTRY HOSPITAL | | 11. BIRTHPLACE (County & State, or foreign country) HOLLY SPRINGS, NORTH CAROLINA U.S.A. | |
| 13. FATHER'S NAME JESSIE PEGRAM | | | 14. MOTHER'S MAIDEN NAME DELLIE SPENCE | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I | | 16. SOCIAL SECURITY NO. 240 20 05 08 | | 17. INFORMANT CLIN. RECORDS, VA HOSPITAL FT HOWARD, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 441X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ADENOCARCINOMA PANCREAS WITH DIABETES MELLITUS (c) METASTATIC CARCINOMA REGIONAL LYMPH NODES AND LIVER | | | | | INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE. BENIGN PROSTATIC HYPERTROPHY | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/10/67 , 19__, to 8/20/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/20/67 , 19__, and that death occurred at 2:40AM , from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <i>Jorge A. Fabara</i> | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 8/21/67 | |
| 22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M. D. | | 22d. ADDRESS VAH FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 8-24-67 | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | | 23d. LOCATION (City or town) (County) (State) BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR Chroy O. Wilson | | ADDRESS WILSON FUNERAL HOME | | 25a. REC'D BY REGISTRAR 22 201 | |
| | | ORLEANS STREET, BALTIMORE, MD. | | 25b. SIGNATURE OF REGISTRAR <i>[Signature]</i> | |



To be countersigned by Dr. Chas. F. O'Donnell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10715

10716

| | | | |
|---|---------------------------------|--|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| c. LENGTH OF STAY IN 1b 10715 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | d. STREET ADDRESS 313 E. Melrose Avenue #21212 | |
| e. NAME OF DECEASED First Middle Last Grace E. Perego | | 4 DATE OF DEATH Month Day Year August 1 19 67 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH March 4, 1888 |
| 9 AGE (In years lost birthday) 79 yrs | | 10 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 12 KIND OF BUSINESS OR INDUSTRY ----- | |
| 13 BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland | | 14 CITIZEN OF WHAT COUNTRY? USA | |
| 15 FATHER'S NAME William H. Stuart | | 16 MOTHER'S MAIDEN NAME Sarah E. Poston | |
| 17 WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No | | 18 SOCIAL SECURITY NO. 217-01-7593B | |
| 19 INFORMANT Walter Perego (Husband) | | 20 ADDRESS Same | |
| 21 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION, ACUTE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) Fracture of R Ankle | | INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years 10 Days | |
| 22 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 23 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 24a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 25b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 26 TIME OF INJURY Month, Day, Year Hour: a.m. p.m. 19 | | 27d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 28e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 29f. (City or town) (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from July 29, 1967 , to August 1, 1967 , that (I) (we) lost saw the deceased alive on August 1, 1967 , and that death occurred at 2:10 AM from causes and on the date stated above. | | | |
| 22a. SIGNATURE Frederick J. Vellmer | | 22b. DATE SIGNED August 1, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Frederick J. Vellmer | | 22d. ADDRESS 6100 York Road | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Aug. 3, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | |
| 24. FUNERAL DIRECTOR Eugenia K. Seitz | | 25a. REGD BY REGISTRAR Aug 3 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | 25c. DATE Aug 3 1967 | |
| 25d. ADDRESS Seitz Funeral Home Baltimore, Md. 21212 | | | |

Approved for Medical Examiner
MEDICAL EXAMINER
Signature: _____
Date: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10716

CERTIFICATE OF DEATH

20717

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> | | c. LENGTH OF STAY IN TB <u>YRS</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> | | d. STREET ADDRESS <u>242 Ashland Rd.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>242 Ashland Road</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Robert Kinsey Perry Sr.</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>10</u> Year <u>1967</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 23 1898</u> |
| 9. AGE (In years last birthday) <u>68</u> yrs | | IF UNDER 1 YEAR Months <u>10</u> Days <u>19</u> Hours <u>67</u> Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCH MAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Rail Road</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Benjamin F. Perry</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY ELIZABETH TURNBAUGH</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>721-18-3613</u> | |
| 17. INFORMANT <u>Mrs. Eva R. Perry</u> | | Address <u>Same as #2</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary insufficiency</u> DUE TO (c) <u>Arteriosclerosis</u> <u>Personal coronary thrombosis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u> <u>few yrs</u> <u>about 2 weeks</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home form, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-1-</u> , 19 <u>60</u> , to <u>8-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-9-</u> , 19 <u>67</u> , and that death occurred at <u>9:30</u> A.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>James B. Saffell MD</u> | | 22b. DATE SIGNED <u>8-10-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>James B. Saffell MD</u> | | 22d. ADDRESS <u>Reston, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>Aug. 14 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Jesson</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Sparks, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Wm Cook - Brooks Towson, Towson, Md.</u> | | 25a. REC'D BY REGISTRAR <u>AUG 14 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | |
|---|----------------------------------|---|-------------------------|--|--|--|--|---|--|
| 10717 | | | | | 10718 | | | | |
| CERTIFICATE OF DEATH | | | | | Reg. Dist. No. | | | | |
| 1. PLACE OF DEATH o COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Maryland b COUNTY Baltimore | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anneslie | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mercy Villa | | | | | d. STREET ADDRESS 501 Anneslie Road | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Agnes Last Peters | | | | | 4. DATE OF DEATH Month August Day 3 Year 19 67 | | | | |
| 5 SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH February 18, 1873 | | 9. AGE (In years last birthday) 94 yrs | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS. Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Freeland, Maryland | | 12. CITIZEN OF WHAT COUNTRY? United States | |
| 13. FATHER'S NAME Stinefelt | | | | 14. MOTHER'S MAIDEN NAME ? | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO 216-56-7050 | | 17. INFORMANT Address Mercy Villa Sister M. Carlotta, R.S.M. 6400 Bellona Ave. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 yrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 1, 1965 , to August 4, 1967 , that I last saw the deceased alive on July 29, 1967 , and that death occurred at 4:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 E. Chase St Baltimore Md 21202 DATE SIGNED ACTUAL SIGNATURE Philip D. Flynn M.D. Philip D. Flynn, M.D. PHYSICIAN'S NAME (Type) | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 8/7/67 | | 22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. F. Tibbitts & Sons | | | | | | 24a. REC'D BY REGISTRAR DATE AUG 8 1967 | | 24b. REGISTRAR'S SIGNATURE Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10718

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10719

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|--|---|
| 1 PLACE OF DEATH a COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | c. LENGTH OF STAY IN b. 21229 | |
| c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 728 Warwick Rd. 21229 | | d. STREET ADDRESS 728 Warwick Rd. 21229 | |
| 3 NAME OF DECEASED (Type or print) First John Middle W. Last Pfeifer | | 4 DATE OF DEATH Month August Day 2 Year 1967 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Nov. 23, 1895 |
| 9 AGE (In years last birthday) yrs 71 | | 10 UNDER 1 YEAR Months 1 Days 2 | 11 UNDER 24 HRS Hours 1 Min 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tool & Die Maker | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12 CITIZEN OF WHAT COUNTRY? U.S.A. | | 13 FATHER'S NAME John Pfeifer | |
| 14 MOTHER'S MAIDEN NAME Josephine Kemp | | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | |
| 16 SOCIAL SECURITY NO. 216-07-3406 | | 17. INFORMANT Address Mrs. Anna C. Pfeifer, 728 Warwick Rd., Balto 7 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH 6 mos. |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH none | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. none p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE D. D. Caples | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) D. D. Caples, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 6 Hanover Rd., Baltimore, Md. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22. DATE SIGNED 8-2-67 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/5/67 | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | 23d. LOCATION (City or town) (County) (State) Baltimore Md. |
| 24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave., Balto. 29 | | 25a. REC'D BY REGISTRAR DATE AUG 7 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

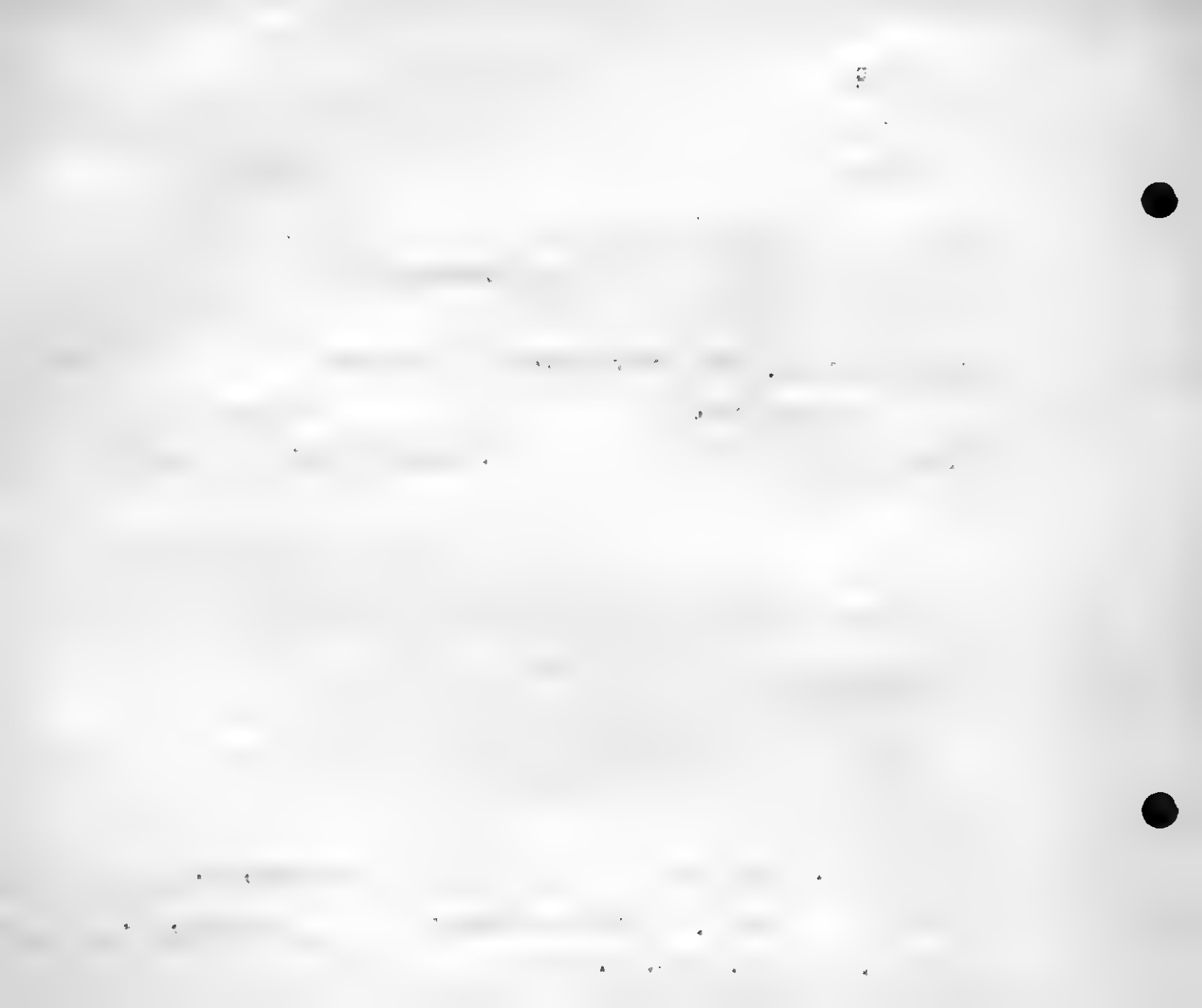
CERTIFICATE OF DEATH

10720

10719

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|---|--|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>XXXXXXXXXX</u> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | c LENGTH OF STAY IN 1b | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cheapeake Manor Nursing Home</u> | | e STREET ADDRESS <u>1317 North View Rd</u> | |
| 3 NAME OF DECEASED (Type or print) First <u>August</u> Middle <u>Pfeil</u> Last <u>Pfeil</u> | | 4 DATE OF DEATH Month <u>8</u> Day <u>24</u> Year <u>1967</u> | |
| 5 SEX <u>Male</u> | 6 COLOR OR RACE <u>White</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>3-26-1906</u> |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired General Mgr. Coal & Grain Business</u> | | 10b KIND OF BUSINESS OR INDUSTRY | |
| 3. FATHER'S NAME <u>Charles Pfeil</u> | | 14 MOTHER'S MAIDEN NAME <u>Margaret ?</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WWI</u> | | 16 SOCIAL SECURITY NO | |
| 17 INFORMANT <u>Mrs. Elizabeth Pfeil</u> Address <u>(Same)</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of bladder & metastasis</u> DUE TO (b) <u>1010</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>1 year</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21. I certify that (I) (the hospital) attended the deceased from <u>January, 1967</u> to <u>August 24, 1967</u> , that (I) (we) last saw the deceased alive on <u>August 24, 1967</u> , and that death occurred at <u>1:30 A.M.</u> , from causes and on the date stated above. | | | |
| 22a SIGNATURE <u>A. Allan Spier</u> | | 22b. DATE SIGNED <u>8/24/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>A. Allan Spier</u> | | 22d ADDRESS <u>Baltimore, Md.</u> | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b DATE THEREOF <u>8/26/67.</u> | 23c NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cemetery</u> | 23d LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u> |
| 24 FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u> | | 25a REC'D BY REGISTRAR DATE <u>AUG 24 1967</u> 25b REGISTRAR'S SIGNATURE <u>[Signature]</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10720

CERTIFICATE OF DEATH

10722

| | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|-----------------------------------|--|--|--|--|--|--------------------------------------|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b Life long d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3511 White Ave. Baltimore Md. d. STREET ADDRESS 3511 White Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) Dorothy Ethel Phillips | | 4. DATE OF DEATH August 11 1967 | | 5. SEX Female | | 6. COLOR OR RACE Can. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 1904 9-30 | | 9. AGE (In years last birthday) 62 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore Md. | | | | 12. CITIZEN OF WHAT COUNTRY? American | | | | | | | |
| 13. FATHER'S NAME Elvie Bennington | | | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | | | 15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) no | | | | | | | |
| 16. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT June Gallack (daughter) | | | | | | 18. ADDRESS Same with the deceased | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cervical Carcinoma DUE TO (b) Cervical Carcinoma DUE TO (c) | | | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from June 26, 1967 to August 11, 1967 , that (I) (we) last saw the deceased alive on August 11 1967 , and that death occurred at 11 M, from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE Shen-Sho Tseong | | | | | | | | | | | | | | | | | | | |
| 22b. DATE SIGNED 8-11-67 | | | | | | | | | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) SHEN-SHO TSEONG, M.D. | | | | | | | | | | | | | | | | | | | |
| 22d. ADDRESS Greater Baltimore Medical Center | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 8/14/67 | | | | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem. | | | | 23d. LOCATION (City, town or county) (State) Balto. Md. | | | | | | | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. | | | | | | | | | | | | | | | | | | | |
| 25a. REC'D BY REGISTRAR AUG 11 1967 | | | | | | | | | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10721

Item #1d R17r #1002

10721

| | | | | |
|--|----------------------------------|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>N.Y.</u> b. COUNTY | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn, N.Y.</u> | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Nursing House in the Pines home</u> | | d. STREET ADDRESS <u>214 Albermarle Rd.</u> | | |
| 3. NAME OF DECEASED (Type or print) First <u>Irene</u> Middle <u>T.</u> Last <u>Phillips</u> | | 4. DATE OF DEATH Month <u>8</u> - Day <u>28</u> Year <u>1967</u> | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 23, 1896</u> | |
| 9. AGE (In years last birthday) yrs <u>71</u> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never Employed</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | |
| 11. BIRTHPLACE (State or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Samuel Richard Phillips</u> | | 14. MOTHER'S MAIDEN NAME <u>Magdaline Kiefer</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT <u>Address</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>1037</u> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I attended the deceased from <u>8-23</u> , 1967, to <u>8-28</u> , 1967, that I last saw the deceased alive on <u>8-28</u> , 1967, and that death occurred at <u>5:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | |
| ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u> | | M.D. <u>6209 Frederick Ave</u> | | |
| PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u> | | <u>Baltimore, 21225 Md.</u> | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | <u>8/31/67</u> | <u>St. Mary's Cem.</u> | <u>Flushing, N.Y.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James M. Furdy</u> | | 24a. REC'D BY REGISTRAR <u>SEP 1</u> | | |
| ADDRESS <u>4781 Bonnie Rd.</u> | | 24b. REGISTRAR'S SIGNATURE <u>James M. Furdy</u> | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (1)
6M 1/67

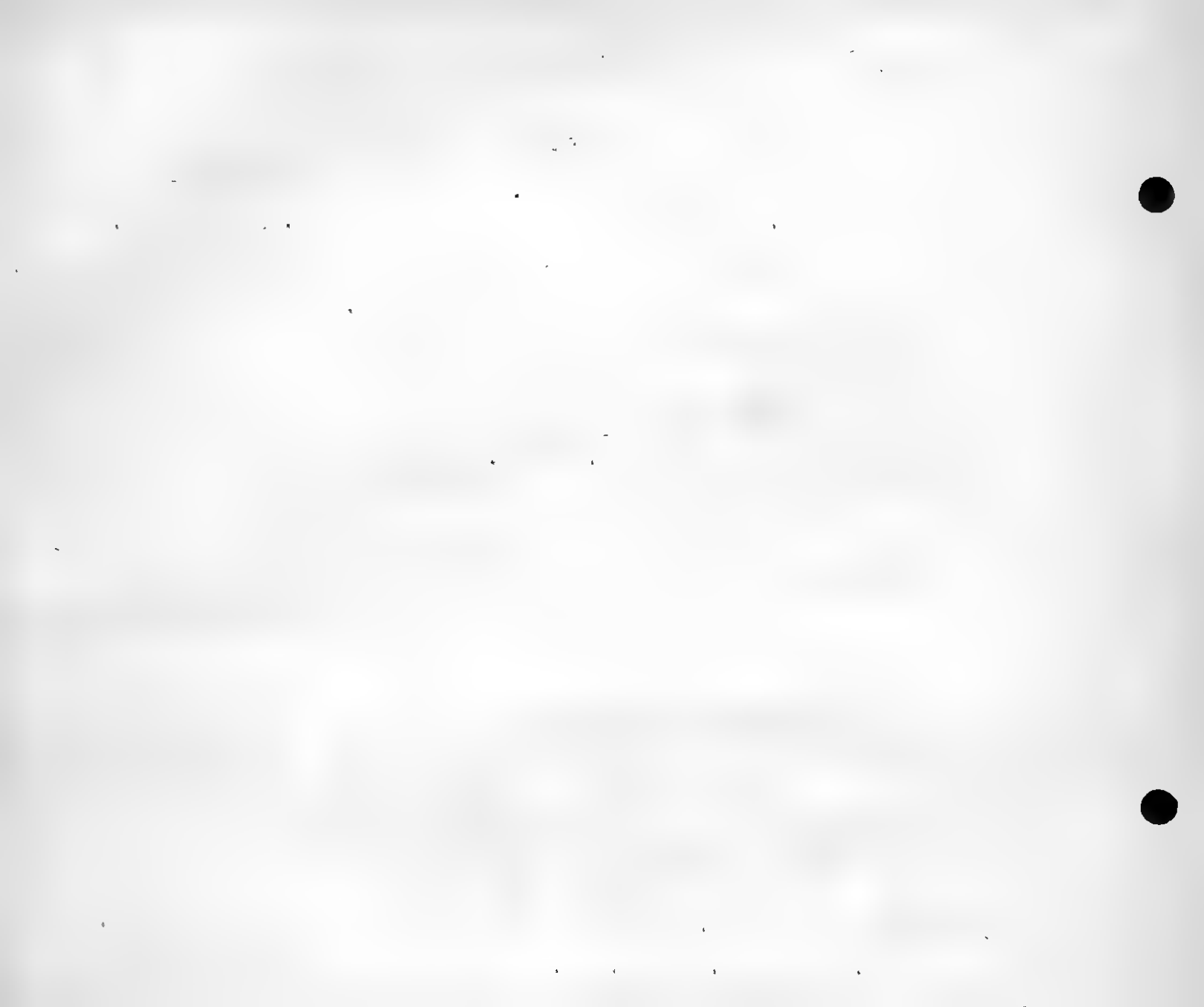
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10722

10723

| | | | | | | | |
|---|--|-----------------------------------|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Towson</u> | | | | c. LENGTH OF STAY IN 1b <u>Baltimore 20204 21204</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>621 St. Francis Road</u> | | | | d. STREET ADDRESS <u>621 St. Francis Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Rosa</u> First <u>Piccinini</u> Last | | | | 4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1967</u> | | | |
| 5. SEX <u>Female</u> | | 6. CO. OR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>May 1, 1896</u> | |
| 9. AGE (In years last birthday) <u>71</u> yrs | | | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | | IF UNDER 24 HRS Hours <u> </u> Min <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u> </u> | | 11. BIRTHPLACE (State or foreign country) <u>Italy</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>Antonio Laudi</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Eugenia Bruni</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | | |
| 16. SOCIAL SECURITY NUMBER <u>24-116-88983</u> | | | | 17. INFORMANT <u>Mr. Anthony Piccinini</u> Address <u>(Same)</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>57 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | |
| PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u> | | | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u> | | | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | | |
| 20f. (City or town) (County) (State) <u> </u> | | | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <u> </u> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| 22. ACTUAL SIGNATURE <u>Charles F. O'Donnell, M.D.</u> | | | | 23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <u> </u> | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <u>Interment</u> | | | | 23b. DATE THEREOF <u>8/9/67</u> | | | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Mausoleum</u> | | | | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Ind. 21214</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>AUG 7 1967</u> | | | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | 27. DATE SIGNED <u>8/5/67</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10723

CERTIFICATE OF DEATH

10723

| | | | |
|--|---|--|---|
| 1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 7 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital | | d. STREET ADDRESS 2207 Lynbrook Avenue | |
| 3 NAME OF DECEASED (Type or print) First FRANK Middle NMI Last PICKENS | | 4. DATE OF DEATH Month August Day 27 Year 1967 | |
| 5 SEX MALE | 6 COLOR OR RACE NEGRO | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH FEBRUARY 3, 1927 |
| 9. AGE (In years last birthday) yrs 40 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | 10b. KIND OF BUSINESS OR INDUSTRY Paper Box Company | |
| 11 BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME HERBERT PICKENS | | 14. MOTHER'S MAIDEN NAME LULA WILLIAMS | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII | | 16. SOCIAL SECURITY NO. 216 16 09 92 | |
| 17. INFORMANT Clinical Records, VA Hospital, Ft Howard, Md | | Address | |
| 18 CAUSE OF DEATH (Enter on 1 one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA DUE TO NUTRITIONAL CIRRHOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PARALYTIC ILEUS SECONDARY TO HYPOKALEMIA DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 8 DAYS | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (1) (this hospital) attended the deceased from 8/20/67 , 19 67 , to 8/27/67 , 19 67 , that (2) (we) lost saw the deceased of ve on 8/27/67 , 19 67 , and that death occurred on 4:45 PM , from causes and on the date stated above. | | | |
| 22a SIGNATURE Rodolfo G. Mingo, M.D. | | 22b. DATE SIGNED 8/28/67 | |
| 22c PHYSICIAN'S NAME (Type) Rodolfo G. Mingo, M.D. | | 22d. ADDRESS VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 8/31/67 | 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR HAILESTAD FUNERAL HOME W. NORTH AVE. BALTIMORE, MD. | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judgen | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10724

CERTIFICATE OF DEATH

10725

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY — | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN TB 133 DAYS c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE - 21224 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS 6437 HARTWATT STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last CECIL A. POMEROY, SR. | | 4. DATE OF DEATH Month Day Year AUGUST 23 19 67 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/14/93 9. AGE (In years lost birthday) 73 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN CROWN, CORK & SEAL CO. | | 10b. KIND OF BUSINESS OR INDUSTRY VALLEY LEE, MARYLAND | |
| 11. BIRTHPLACE (County & State, or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME CHARLES H. POMEROY | | 14. MOTHER'S MAIDEN NAME RUTH CLEMENTS | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I | | 16. SOCIAL SECURITY NO. 213 01 67 21 | |
| 17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PROSTATE WITH METASTASES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CACHEXIA AND ANEMIA PROBABLY SECONDARY TO #1 DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (X) (this hospital) attended the deceased from 4/12/67 , 19__ to 8/23/67 , 19__, that (X) (we) last saw the deceased alive on 8/23/67 , 19__, and that death occurred 12:00 Noon from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Howard G. Kramer</i> M.D. | | 22b. DATE SIGNED 8/23/67 | |
| 22c. PHYSICIAN'S NAME (Type) HOWARD G. KRAMER, M. D. | | 22d. ADDRESS VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 8/28/67 | 23c. NAME OF CEMETERY OR CREMATORY MORELAND MEM. | 23d. LOCATION (City or Town) (County) (State) BALTO. CO. MD |
| 24. FUNERAL DIRECTOR <i>Walter Brooks Bradley</i> | | 25a. REC'D BY REGISTRAR WALTER BROOKS BRADLEY 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

WILLOW SPRING ROAD, BALTIMORE, MD.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10725

10726

| | | | |
|---|--|--|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore (Towson) | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | d STREET ADDRESS 3514 E. Joppa Road #21234 | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Edna Claire Preisinger | | 4 DATE OF DEATH Month Day Year August 20 1967 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 8, 1907 |
| 9 AGE (In years last birthday) 60 yrs | | IF UNDER 1 YEAR Months Days Hours Min 0 0 0 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John Volker. | | 14. MOTHER'S MAIDEN NAME Margaret Corner. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. 217-16-5006 | |
| 17. INFORMANT Margaret Wassenus, 3514 E. Joppa Rd. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. xxx diffuse pulmonary fibrosis. DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (H) (this hospital) attended the deceased from August 19, 1967 , to August 20, 1967 that (H) (we) last saw the deceased alive on August 20, 1967 , and that death occurred at 12:40 AM from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Lawrence F. Misanik</i> | | 22b. DATE SIGNED August 20, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D. | | 22d. ADDRESS 7620 York Road, Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial. | 23b. DATE THEREOF 8/23/67 | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, inc. 5305 Harford Rd. | | 25a. REC'D BY REGISTRAR AUG 22 1967 | |
| 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

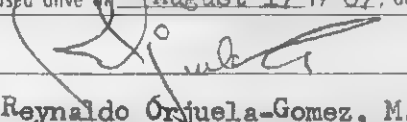

M

10726

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10727

| | | | |
|--|--|---|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore, 21206 | |
| c. LENGTH OF STAY IN 1b | | d. STREET ADDRESS 5910 Starleigh Rd. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) EMMA E. PRESSON | | 4 DATE OF DEATH Month August Day 17 Year 1967 | |
| 5 SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8 DATE OF BIRTH April 19, 1900 |
| 9 AGE (In years - last birthday) 67 yrs. | | 10 UNDER 1 YEAR Months 67 Days 0 Hours 0 Min 0 | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Telephone Oper. Telephone | | 10b KIND OF BUSINESS OR INDUSTRY Telephone | |
| 11 BIRTHPLACE (County & State, or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME John B. Neal | | 14. MOTHER'S MAIDEN NAME Susan Howard | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-05-0291 | |
| 17. INFORMANT Mrs. Mary Turc, 5910 Starleigh Road | | Address | |
| 18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Acute hemorrhagic pancreatitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute myocardial infarction | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 16, 1967 to August 17, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 17, 1967 , and that death occurred at 1:00 AM from causes and on the date stated above. | | | |
| 22a. SIGNATURE  | | 22b. DATE SIGNED August 17, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D. | | 22d. ADDRESS 7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/21/67 | 23c. NAME OF CEMETERY OR CREMATORY Meadow Ridge | 23d. LOCATION (City or Town) (County) (State) Elkridge, Md. |
| 24. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road. | | 25a. REC'D BY REGISTRAR AUG 21 1967 | |
| 25b. REGISTRAR'S SIGNATURE  | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10727

CERTIFICATE OF DEATH

10728

| | | | |
|--|---|---|---|
| 1 PLACE OF DEATH a COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY _____ | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills | | c LENGTH OF STAY IN 1b 11½ months | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital | | d STREET ADDRESS 1311 Glenwood Avenue | |
| 3 NAME OF DECEASED (Type or print) Charles Howard PRESTON | | 4. DATE OF DEATH Month 8 Day 17 Year 1967 | |
| 5. SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 10-20-52 |
| 9 AGE (In years lost birthday) yrs 14 | | IF UNDER 1 YEAR Months Days Hours Min. 14 | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent | | 10b KIND OF BUSINESS OR INDUSTRY none | |
| 11. BIRTHPLACE (County & State, or foreign country) Baltimore City, Md. | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Emmert Howard Preston | | 14. MOTHER'S MAIDEN NAME Mary Cecelia Schanberger | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | |
| 17 INFORMANT Rosewood Records, Owings Mills, Maryland | | Address _____ | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia DUE TO (b) Severe brain contusion DUE TO (c) Car accident | | INTERVAL BETWEEN ONSET AND DEATH 1 day 3 yrs | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/> | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Child was struck by truck while riding a bicycle | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. June 24 1964 | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street | 20f (City or town) (County) (State) |
| 21. I certify that (this hospital) attended the deceased from 8-30 , 19 66 , to 8-17 , 19 67 , that (we) last saw the deceased alive on 8-17 , 19 67 , and that death occurred at 9:25 A.M. on causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>[Signature]</i> | | 22b DATE SIGNED 8/17/67 | |
| 22c. PHYSICIAN'S NAME (Type) Rosewood State Hospital | | 22d ADDRESS Rosewood State Hospital | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b DATE THEREOF 8/21/67. | 23c NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL CEM. | 23d LOCATION (City or Town) (County) (State) Baltimore, Md. |
| 24 FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | 25a REC'D BY REGISTRAR AUG 18 1967 | |
| | | 25b REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

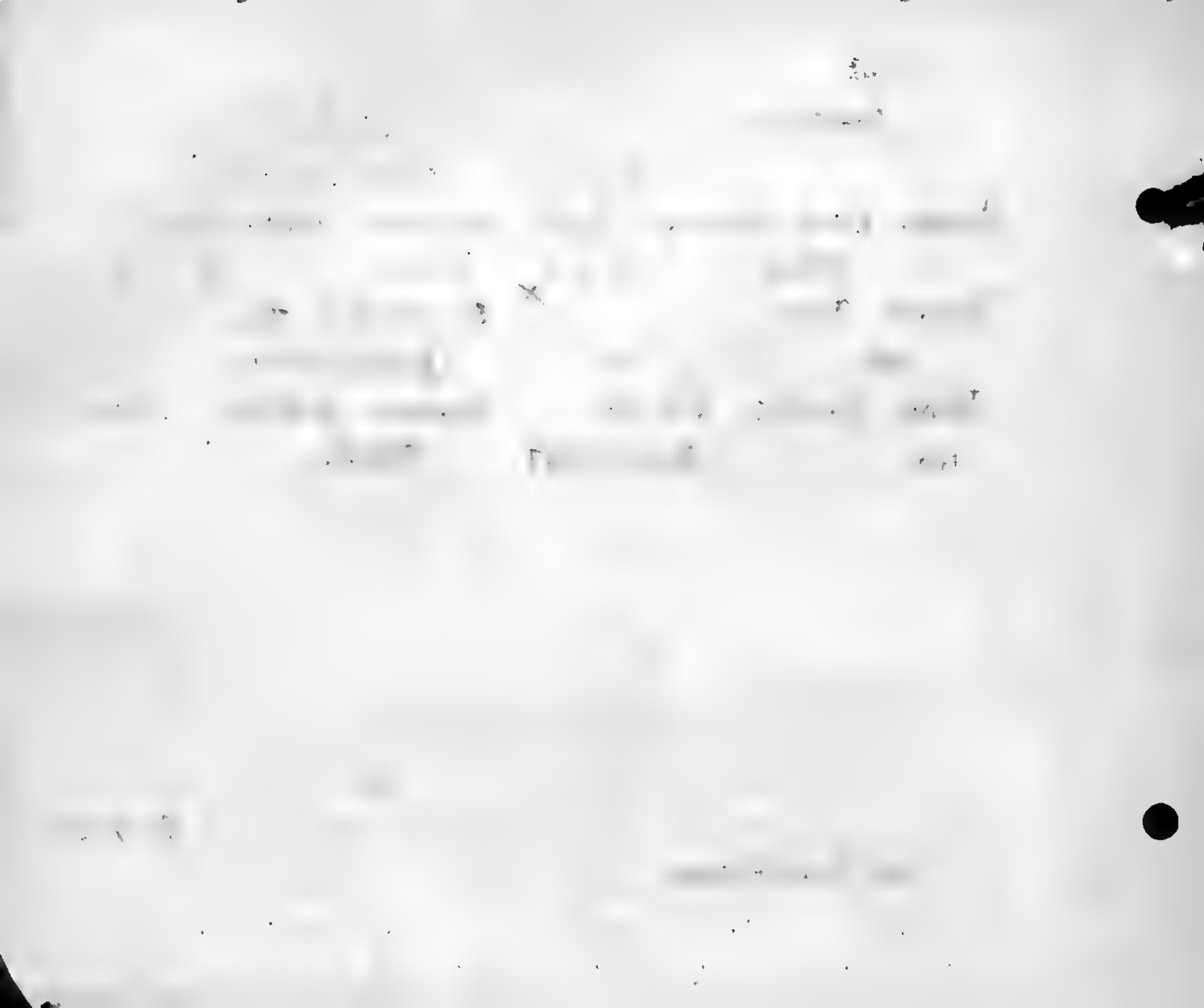
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M. 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10728 CERTIFICATE OF DEATH 10729

| | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|---------------------------------|--|---|--|------------------------------------|--|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b 11 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Balto. Medical Center | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS Hopkins Apts. #601 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First ORA Middle MAY Last Price | | 4. DATE OF DEATH Month 8 Day 7 Year 1967 | | 5. SEX Female | | 6. COLOR OR RACE CAU. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5-24-93 | | 9. AGE (In years last birthday) 74 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (RET.) BOOKKEEPER | | | | 10b. KIND OF BUSINESS OR INDUSTRY — | | | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME John Curtis Price | | | | 14. MOTHER'S MAIDEN NAME Marie Estelle Stone | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. 212-07-5807 | | | | 17. INFORMANT MRS. Catherine Herrmann Address 4712 HAZELWOOD AVE | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized lymphosarcoma & Diabetes (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus | | | | | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 7.28i 1967 , to 8.7. 1967 , that (I) (we) last saw the deceased alive on 8.7. 5:54 PM 1967 , and that death occurred at 7 P.M. from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE Ret. M. Basseri | | | | | | | | | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) DR. Brantigan | | | | 22d. ADDRESS | | | | 22b. DATE SIGNED 8-7-67 | | | | M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 8/12/67 | | | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. | | | | 23d. LOCATION (City, town or county) (State) Balto. Md. | | | | | | | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. | | | | | | | | | | | | | | | | | | | |
| 25a. REC'D BY REGISTRAR AUG 10 1967 | | | | | | | | | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | | | | | | | | | | | | | | | | |



CERTIFICATE OF DEATH

107228

10730

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN TB 2yr2mth10dys | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | d. STREET ADDRESS Route 1 - Box 3764 | |
| 3. NAME OF DECEASED (Type or print) First Ida Middle E. Last Proctor | | 4. DATE OF DEATH Month August Day 21 Year 19 67 | |
| 5. SEX female | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 25, 1921 |
| 9. AGE (In years last birthday) yrs 46 | | IF UNDER 1 YEAR Months 1 Days 21 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (County & State, or foreign country) U. S. | | 12. C.T.ZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME Joseph | | 14. MOTHER'S MAIDEN NAME Mary | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive heart failure DUE TO (b) Hypertension DUE TO (c) Obesity | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (If this hospital) attended the deceased from June 11, 1966 to Aug. 21 19 67 that (I) (we) lost saw the deceased alive on Aug. 21 19 67 , and that death occurred at 1:55 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Anthony J. Young</i> | | 22b. DATE SIGNED 8-22-67 | |
| 22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D. | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Aug. 25/67 | 23c. NAME OF CEMETERY OR CREMATORY Resurrect. Cem. Clinton, R.G. Co. Md. | |
| 24. FUNERAL DIRECTOR Martell Adams | | 25. FILED BY REGISTRAR Aug 25 1967 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10730

CERTIFICATE OF DEATH

10731

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | c. LENGTH OF STAY IN 1b 50yrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St Joseph Hospital | | d. STREET ADDRESS 6101 Loch Raven Blvd. | |
| 3. NAME OF DECEASED (Type or print) First Lillian Middle Adele Last Propf | | 4. DATE OF DEATH Month 8 Day 26 Year 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/17/1898 |
| 9. AGE (In years last birthday) yrs. 69 | | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John Long | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO 214-20-6732 | |
| 17. INFORMANT Mr. John T. Propf-6028 Chesworth Rd-28 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/26/1967 to 8/26/1967 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/26/1967 , and that death occurred at 10p M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>[Signature]</i> | | 22b. DATE SIGNED August 27, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D. | | 22d. ADDRESS St. Joseph Hospital Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/29/67 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Maria Cem. | 23d. LOCATION (City or Town) (County) (State) Towson Balto. Co. |
| 24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. 6500 York Rd 21212 | | 25a. REC'D BY REGISTRAR AUG 31 1967 | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10731

10732

| | | | |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Dulaney Towson Nursing Home</u> | | d. STREET ADDRESS <u>2317 Linden Avenue</u> | |
| 3. NAME OF DECEASED (Type or print) <u>CELIA</u> First Middle Last <u>PUGATCH</u> | | 4. DATE OF DEATH <u>August 8</u> Month Day Year <u>19 67</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>65</u> yrs. <u>65</u> yrs. <u>65</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Russia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Selig Luboff</u> | | 14. MOTHER'S MAIDEN NAME <u>Chiah ?</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> [If yes, give war or dates of service] | | 16. SOCIAL SECURITY NO. <u>317-48-8654</u> | |
| 17. INFORMANT <u>Mr. Melvin Pugatch, 3715 Seven Mile Lane</u> Address <u>#8</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Failure</u> DUE TO <u>Acute massive myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic CVD</u> DUE TO <u>Diabetic mellitus</u> (c) <u>Senility</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Nov 1</u> , 19 <u>65</u> , to <u>Aug 8</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>Aug 8</u> , 19 <u>67</u> , and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>William D Appleford</u> M.D. <u>5501 Park Heights N. Baltimore MD</u> | | | |
| PHYSICIAN'S NAME (Type) <u>William D Appleford</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>8/9/67</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Workman Circle</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u> ADDRESS | | 24a. REC'D BY REGISTRAR <u>AUG 14 1967</u> DATE | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Juanita Judge</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10732

CERTIFICATE OF DEATH

10733

| | | | |
|---|--------------------------|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson c. LENGTH OF STAY IN 1b 4 yrs, 3 mos | | 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) HILDA FAYE RAMSAY | | 4 DATE OF DEATH 8 - 16 - 1967 | |
| 5 SEX F. | 6 COLOR OR RACE W | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 AGE (In years lost birthday) 55 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waitress | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (County & State, or foreign country) W. Virginia | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME Wilbur Hazlett | | 14. MOTHER'S MAIDEN NAME Faye Hughes | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16 SOCIAL SECURITY NO 035-14-7036 | |
| 17 INFORMANT Records, Mt. Wilson State Hospital | | Address | |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cor pulmonale DUE TO (b) Far advanced, pulmonary Tb, active DUE TO (c) 4 years. | | INTERVAL BETWEEN ONSET AND DEATH one year | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(a) Chronic peptic ulcer in stomach | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 5/20/1963 , to 8/16/1967 , that (I) (we) last saw the deceased alive on 8/16/1967 , and that death occurred at 4:50AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE W. Newcomer | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Supt. | | 22d. ADDRESS Mt. Wilson, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE THEREOF 8/18/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Greenmount Cen. | | 23d. LOCATION (City or Town) (County) (State) Balto. | |
| 24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home | | 25a. REC'D BY REGISTRAR DATE AUG 21 1967 | |
| 25b. REGISTRAR'S SIGNATURE Judge | | 25c. ADDRESS 6500 York Road 21212 | |

10733

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

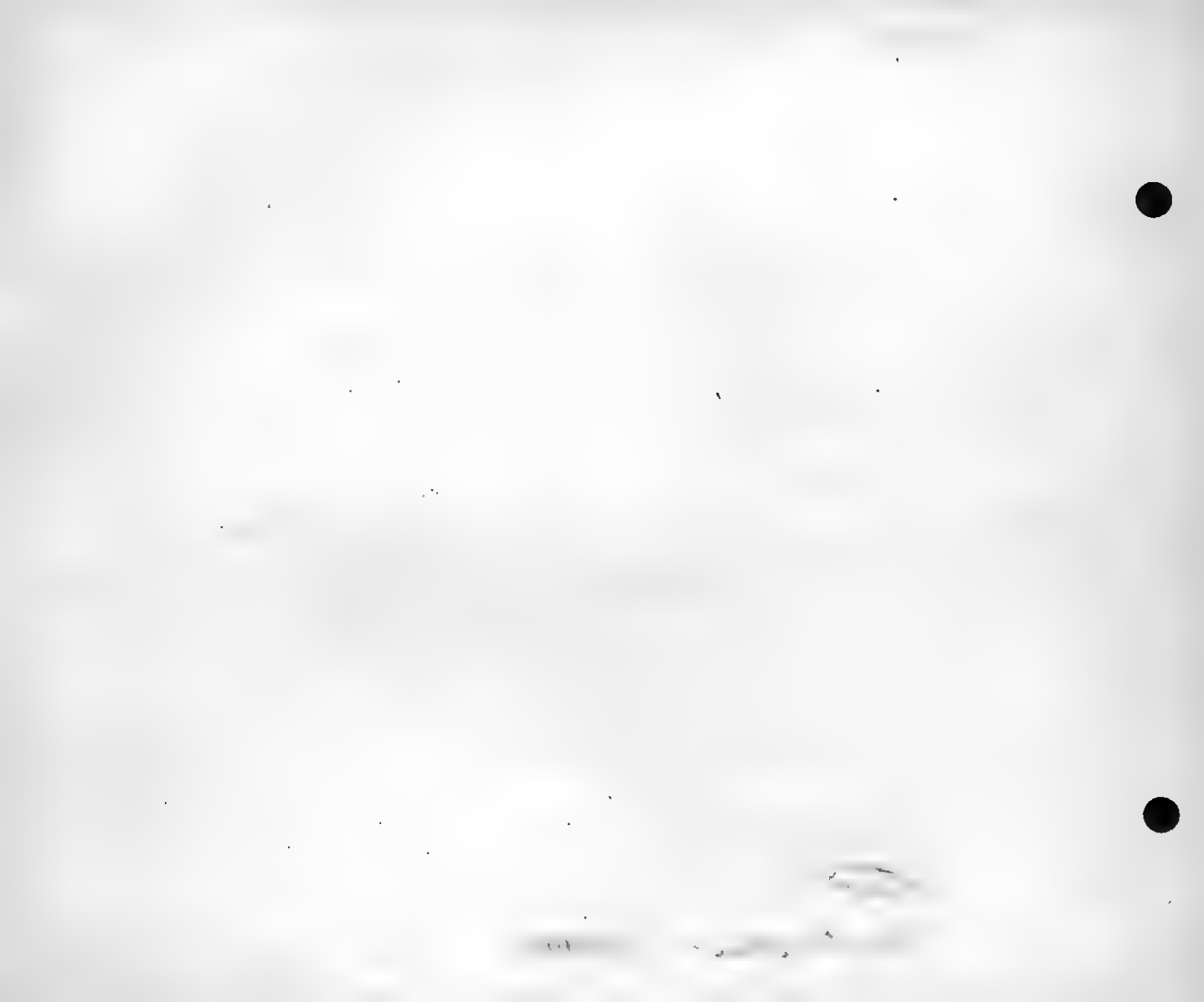
| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | d. STREET ADDRESS | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) HARRY NELSON (OR) HARRY RAY | | 4. DATE OF DEATH Month Aug. Day 24 Year 1967 | |
| 5. SEX M | 6. COLOR OR RACE Cau. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-12-11 |
| 9. AGE (In years, last birthday) 56 YRS | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photo. Engraver | |
| 11. BIRTHPLACE (County & State, or foreign country) BALTO. Md. | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME Harry Francis Ray | | 14. MOTHER'S MAIDEN NAME Myrtle Thomas | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-07-4312 | |
| 17. INFORMANT Mrs. Dolores M. Ray | | Address Same. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure DUE TO (b) C.A. of Lung with generalized metastases DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 8-7, 1967 , to 8-24, 1967 , that (I) (we) last saw the deceased alive on 8-24, 1967 , and that death occurred at 3:30 P.M. , from causes and on the date stated above. | | | |
| 22a. SIGNATURE Ruth M. Bassiri | | 22b. DATE SIGNED 8.24.67 | |
| 22c. PHYSICIAN'S NAME (Type) DR. BASSIRI | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) Burial | 23b. DATE THEREOF 8/28/67 | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem. | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. |
| 24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. | | 25a. REC'D BY REGISTRAR AUG 25 1967 | |
| ADDRESS | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---|--|-------------------------------------|--|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY Pa | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson | | | | c. LENGTH OF STAY IN 1b 18 min. | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex 21221 | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Balto. Medical Center | | | | | | d. STREET ADDRESS 900 Virginia Ave. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) BABY BOY REED | | | | | | 4. DATE OF DEATH 8 21 19 67 | | Month | | Day Year | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8-21-67 | | 9. AGE (In years last birthday) 18 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) BALTO. COUNTY | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME CLAY BENNETT REED, JR. | | | | | | 14. MOTHER'S MAIDEN NAME BRUZZDZINSKI | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory anoxia DUE TO (b) New-onset delirium - Prematurity DUE TO (c) Thrombotic stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Henry M. Beil | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 8/21/67 | |
| 22c. PHYSICIAN'S NAME (Type) Town, Charles H | | | | | | 22d. ADDRESS 700 N. Charles St | | | | | |
| 23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> REMOVAL (Specify) | | 23b. DATE THEREOF 8/24/67 | | 23c. NAME OF CEMETERY OR CREMATORY Greater Baltimore Med. Center | | | | 23d. LOCATION (City, town or county) (State) Baltimore, Md | | | |
| 24. FUNERAL DIRECTOR Preisenecker | | | | | | ADDRESS GBMC | | 25a. REC'D BY REGISTRAR AUG 28 1967 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |



10735

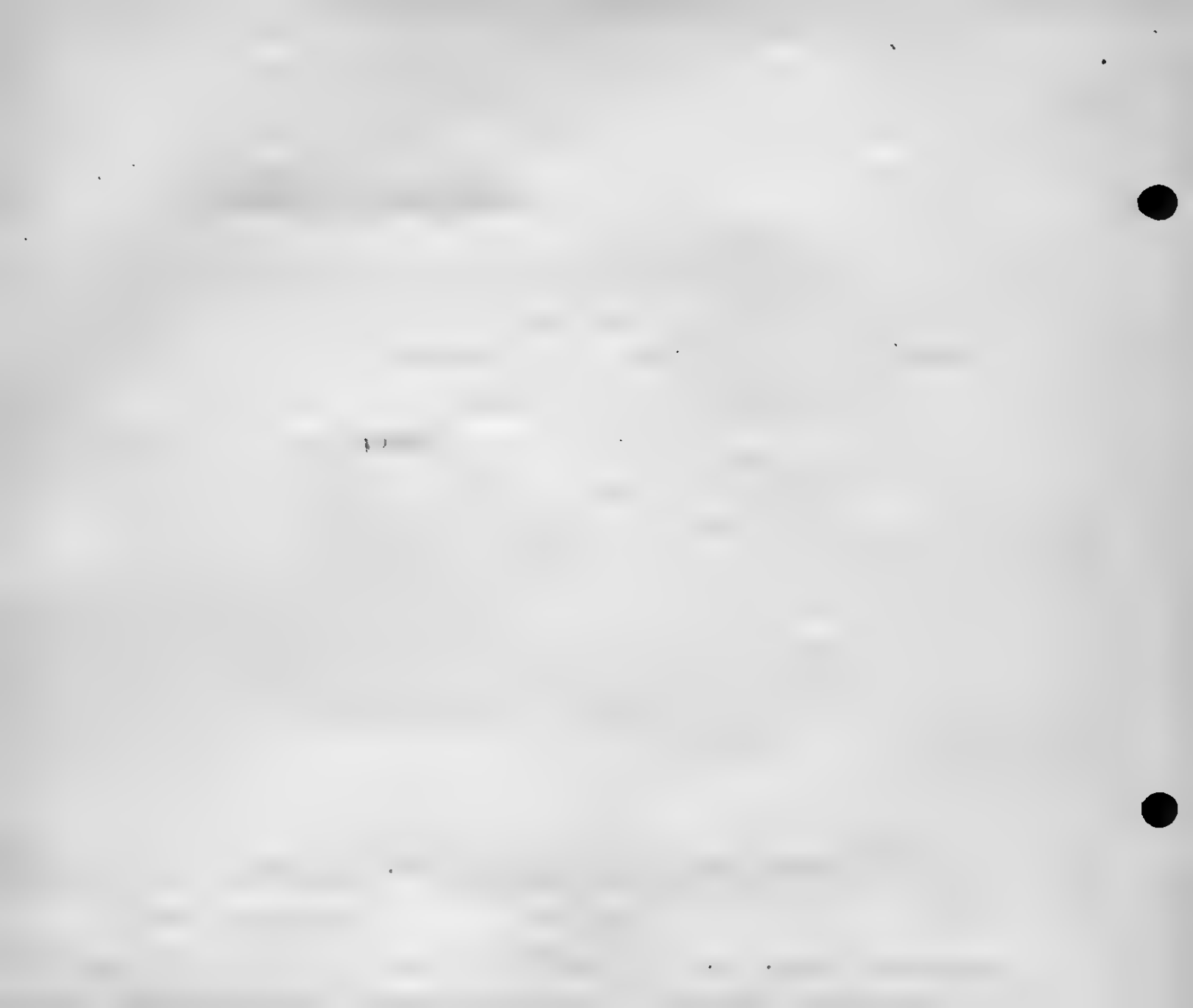
CERTIFICATE OF DEATH

10736

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN b. <u>Baltimore</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Milford Manor Nursing Home</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>7121 PARK HEIGHTS AVE.</u> | | IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Lena Reicher</u> | | 4. DATE OF DEATH <u>8 - 30 1967</u> | | 5. SEX <u>Female</u> | |
| 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11-11-1886</u> | |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Jacob Golden</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Sarah</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> | |
| 17. INFORMANT <u>REICHER</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 4201 DUE TO <u>C.V.A. - Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>C.V.A. - Congestive Heart Failure</u> DUE TO (c) <u>C.V.A. - Congestive Heart Failure</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from 19... to 19..., that (I) (we) last saw the deceased alive on 19..., and that death occurred at 8:15 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Bernard Cohen</u> | | 22b. PHYSICIAN'S NAME (Type) <u>Bernard Cohen</u> | | 22c. DATE SIGNED | |
| 22d. ADDRESS <u>3501 St. Paul Street</u> | | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>8/31/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Beth Tfiloh</u> | |
| 23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u> | | 23e. REC'D BY REGISTRAR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u> | | | |
| 23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | DATE <u>SEP 5 1967</u> | | | |

MEDICAL CERTIFICATION



10736

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10737

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. This may be retained for your files.

TO BURIAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|-------------------------------------|---|---|
| 1 PLACE OF DEATH a COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21) | | c. LENGTH OF STAY N 1b Essex (21) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2 Louella Ave. | | d. STREET ADDRESS 2 Louella Ave. | |
| 3 NAME OF DECEASED (Type or print) FREDRICK DOUGLAS REID | | 4 DATE OF DEATH Month August 27, Day 19 Year 67 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Oct. 18, 1893 |
| 9 AGE (in years last birthday) 73 yrs | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | |
| 10b. KIND OF BUSINESS OR INDUSTRY Maintenance | | 11 BIRTHPLACE (State or foreign country) Pennsylvania | |
| 12 CITIZEN OF WHAT COUNTRY? USA | | 13 FATHER'S NAME Conrad Reid | |
| 14 MOTHER'S MAIDEN NAME Sophia | | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes (If yes give war or dates of service) WWI | |
| 16 SOCIAL SECURITY NO 705 09 2996A | | 17. INFORMANT Frances Reid Address Same | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day Year hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Theo C Patterson M.D. | | 22. DATE SIGNED 8/27/67 | |
| EXAMINER'S NAME (Type) THEO C PATTERSON | | 105 Main St., Dundalk, Md. | |
| 23a. BURIAL (CREMATION) REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/30/67 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery | |
| 23d. LOCATION (City or town) (County) (State) Baltimore, Md. | | 25a. REC'D BY REG STRAR AUG 30 1967 | |
| 24. FUNERAL DIRECTOR James E. Bruzdziński ADDRESS 1407 Eastern Ave. Balto 21 | | 25b. REG STRAR'S SIGNATURE Charles Judge | |

10737

CERTIFICATE OF DEATH

10738

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN 1b 1 month | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, 7620 York Rd. | | d. STREET ADDRESS 320 Linwood Avenue | |
| 3. NAME OF DECEASED (Type or print) First JANETT Middle LOUISE Last RHOADS | | 4. DATE OF DEATH Month August Day 29 Year 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 7, 1932 |
| 9. AGE (In years last birthday) 34 yrs | | 10. IF UNDER 1 YEAR Months 29 Days 29 Hours 29 Min. 29 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary | | 10b. KIND OF BUSINESS OR INDUSTRY Manufacturing | |
| 11. BIRTHPLACE (County & State or foreign country) Kiskiminitas Tship, PENNA. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CLARENCE J. KING | | 14. MOTHER'S MAIDEN NAME Mildred O. Young | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO 161-26-3147 | |
| 17. INFORMANT Husband 838-7219 Address 320 Linwood Avenue Bel Air, Maryland 21014 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinomatosis DUE TO 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of Cervix DUE TO (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that he (this hospital) attended the deceased from July 29, 1967 to August 29, 1967 , that he (we) last saw the deceased alive on August 29, 1967 , and that death occurred at 4:30 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE D. Antonio G. DeLeon, M.D. | | 22b. DATE SIGNED August 29, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) G. Antonio DeLeon, M.D. | | 22d. ADDRESS 7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVA. (Specify) Burial | 23b. DATE THEREOF August 31, 1967 | 23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens | 23d. LOCATION (City or Town) (County) (State) Bel Air, Harford Co. Maryland 21014 |
| 24. FUNERAL DIRECTOR Joseph William Foster | | 25a. REC'D BY REGISTRAR AUG 31 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---------------------------------|--|--|--|--|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | | | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Edgemere | | | | c. LENGTH OF STAY IN lb 3 Weeks | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) REVER'S FARM, SPARRONS 1721219 | | | | | | d. STREET ADDRESS 628 47th Street | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Raymond Eugene Rice | | | | | | 4 DATE OF DEATH Month Day Year August 20 1967 | | | | | |
| 5 SEX Male | | 6 COLOR OR RACE White | | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH 2/5/33 | | 9 AGE (in years last birthday) yrs 34 | | 10 IF UNDER 1 YEAR Months Days Hours Min 24 0 0 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer | | | | 10b. KIND OF BUSINESS OR INDUSTRY DiFerdinando & Sons | | | | 11 BIRTHPLACE (State or foreign country) Virginia | | 12 CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13 FATHER'S NAME Gilbert Rice | | | | | | 14 MOTHER'S M A DEN NAME Marie Oats | | | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 2 | | | | 16 SOCIAL SECURITY NO 274-32-5788 | | 17 INFORMANT (Wife) Address 21224 Mrs. Joyce Rice, 628 47th Dundalk, Md. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DROWNED DUE TO 7-10 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) | | | | | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item B) Went swimming, turned & capsized Boat | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 10 am 8-19 1967 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Brick Row | | 20f. (City or town) (County) (State) Harrisonburg - 19 Md. | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Melvin B. Davis M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 6800 Morn- DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ington Rd. Address (Street, city, town, or county) Dundalk, Md. 22. DATE SIGNED 8/21/67 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or town) (County) (State) | | | |
| Burial | | 8/22/67 | | Mt. Clinton Church of God | | | | Harrisonburg, Virginia | | | |
| 24. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | | | | 25a. RECEIVED BY REGISTRAR DATE AUG 22 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10739
CERTIFICATE OF DEATH
10740

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b 8 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 10 Winona Ave | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 10 Winona Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Garnet Middle G. Last Richmond | | | | 4. DATE OF DEATH Month August Day 7 Year 1967 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 18, 1896 | |
| 9. AGE (In years last birthday) 71 yrs. | | IF UNDER 1 YEAR Months 7 Days 10 | | IF UNDER 24 HRS. Hours 10 Min. 00 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) West Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | |
| 13. FATHER'S NAME Harve Neely | | | | 14. MOTHER'S MAIDEN NAME Malinda Underwood | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 232-01-3608A | | 17. INFORMANT (Son) Karl S. Richmond, 12 Winona Ave, Dundalk, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior wall Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 72 hr. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 6-14, 1967 to 8-7, 1967 that (I) (we) last saw the deceased alive on 7-10, 1967 and that death occurred at 5 AM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Wyman K. Wong | | | | 22b. DATE SIGNED 8/8/67 | | 22c. PHYSICIAN'S NAME (Type) Wyman K. Wong | |
| 22d. ADDRESS 3209 Old North Point Rd. Dundalk, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/10/67 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Pk. Cem. | | 23d. LOCATION (City, town or county) (State) Dorsey, Maryland | |
| 24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | | 25a. REC'D BY REGISTRAR AUG 10 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10740

CERTIFICATE OF DEATH

10741

| | | | | | | | |
|---|--|--|------------------------|---|---|--|----------------------------------|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | | c LENGTH OF STAY IN 1b | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital | | | | d STREET ADDRESS 701 Oakland Ave. (Home) 6116 Belair Rd. (Gould Nursing) | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Martha Middle T. Last Robinson | | | | 4 DATE OF DEATH Month August Day 31 Year 1967 | | | |
| 5 SEX female | | 6 COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH 6/5/1892 | |
| 9 AGE (In years last birthday) 74 7/8 yrs | | 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Homemaker | | 10b KIND OF BUSINESS OR INDUSTRY -- | | 11 BIRTHPLACE (County & State, or foreign country) Harford Co., Maryland | |
| 12 CITIZEN OF WHAT COUNTRY? USA | | | | 13 FATHER'S NAME James Allender | | | |
| 14 MOTHER'S MAIDEN NAME Charlotte Cloman | | | | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | |
| 16 SOCIAL SECURITY NO 216-01-3701D | | 17 INFORMANT Lillian B. Gonder (Daughter) | | Address 3916 Woodlea Ave Sa 21206 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pyelonephritis 6000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic cardiovascular disease. Diabetes mellitus. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that (this hospital) attended the deceased from August 17, 1967 , to August 31, 1967 , that (we) last saw the deceased alive on August 31, 1967 , and that death occurred at 5:00aM , from causes and on the date stated above. | | | | | | | |
| 22a SIGNATURE Reynaldo Orjuela-Gomez, M.D. | | | | 22b DATE SIGNED August 31, 1967 | | 22c PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D. | |
| 22d ADDRESS 7620 York Rd., Towson, Md. 21204 | | 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | |
| 23b DATE THEREOF 9/2/1967 | | 23c NAME OF CEMETERY OR CREMATORY Mountain Cristian Church Cemetery | | 23d LOCATION (City or Town) (County) (State) Bel Air, Md. | | | |
| 24 FUNERAL DIRECTOR Eugenia K. Seitz 5209 York Road Seitz Funeral Home Balto. Md. 21212 | | | | 25a REC'D BY REGISTRAR SEP 1 1967 | | 25b REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10741

CERTIFICATE OF DEATH

10742

| | | | | | |
|--|--|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson | | c. LENGTH OF STAY in 1b 21 days | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First John Middle Bartholomew Last Rock | | | 4. DATE OF DEATH Month Aug. Day 30 Year 1967 | | |
| 5. SEX Male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-30-85 | | 9. AGE (In years last birthday) 82 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Massachusetts | |
| 13. FATHER'S NAME William Rock | | | 14. MOTHER'S MAIDEN NAME Catherine Carey | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO 022-05-7115 | | 17. INFORMANT Records, Mt. Wilson State Hospital | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of coronary artery DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days 10 years 15 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary fibrosis | | | | | 19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 8-9, 1967 to 8-30, 1967 that (I) (we) last saw the deceased alive on 8-30, 1967 and that death occurred at 5:45 PM from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE W. Newcomer | | | M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED 8-30-67 |
| 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Supt. | | | 22d. ADDRESS Mt. Wilson, Maryland | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 9-2-1967 | 23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery | | 23d. LOCATION (City or Town) (County) (State) Medford, Massachusetts | |
| 24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 21229 | | | 25a. REC'D BY REGISTRAR SEP 1 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---|--|-------------------------------------|--|---|--|--|--|--|---|--|--|
| 10742 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 10743 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 36 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3721 Marmon Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Anna Julia Roeder | | | | | | 4. DATE OF DEATH Month Day Year 8 8 1967 | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE Cau | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3/6/76 | | 9. AGE (In years last birthday) 91 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Wiesner | | | | | | 14. MOTHER'S MAIDEN NAME Lessner | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. ---- | | 17. INFORMANT Regina R. Hornung-3721 Marmon Ave. | | | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/3/1967 , to 8/8, 1967 , that (I) (we) last saw the deceased alive on 8/8/1967 , and that death occurred at 7:30M , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE John E. Adams 22c. PHYSICIAN'S NAME (Type) John E. Adams, M.D. | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS 6701 N. Charles Street | | 22b. DATE SIGNED 8/9/67 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8-11-67 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | | | 23d. LOCATION (City, town or county) (State) Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR Ellsworth Armacost-4600 Liberty Hghts. Ave. | | | | | | 25a. REC'D BY REGISTRAR AUG 11 1967 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---------------|--|-------|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 10743 | | Item #2d Film | | 10744 | | | | | | | |
| 1. PLACE OF DEATH | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) | | | | | |
| a. COUNTY BALTIMORE | | | | | | a. STATE MARYLAND | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | | | | | b. COUNTY BALTIMORE | | | | | |
| c. LENGTH OF STAY IN 1b | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MILFORD MANOR NURSING HOME | | | | | | d. STREET ADDRESS 121 Park Hgts. Ave. | | | | | |
| 3. NAME OF DECEASED (Type or print) HATTIE | | | | | | 4. DATE OF DEATH AUG 27 1967 | | | | | |
| 5. SEX F | | | | | | 6. COLOR OR RACE W | | | | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | 8. DATE OF BIRTH 9/28/1873 | | | | | |
| 9. AGE (In years last birthday) 93 yrs. | | | | | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | | | | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME SAMUEL | | | | | | 14. MOTHER'S MAIDEN NAME JOHANNA | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | | | | | 16. SOCIAL SECURITY NO. | | | | | |
| 17. INFORMANT MRS EDITH R. BLUM | | | | | | Address 7121 PARK HEIGHTS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 7221 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (the hospital) attended the deceased from July 1, 1967 to Aug 27, 1967, that (I) (we) last saw the deceased alive on Aug 27, 1967 and that death occurred at 3 PM, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE James C. Miller | | | | | | 22b. DATE SIGNED 8/28/67 | | | | | |
| 22c. PHYSICIAN'S NAME (Type) James C. Miller | | | | | | 22d. ADDRESS 2217 South Rd | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | 23b. DATE THEREOF 8/28/67 | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Balto Hebrew | | | | | | 23d. LOCATION (City, town or county) (State) Balto Md | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Sydney S. Lewis & Son, INC | | | | | | 25. REC'D BY REGISTRAR AUG 29 1967 | | | | | |
| 25a. REGISTRAR'S SIGNATURE Garcia, Md. | | | | | | 25b. REGISTRAR'S SIGNATURE James C. Miller | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
|--|--|---------------------------|------------------------------------|--|---|--|--|--|---|--|--|-----------------------------|--|--|
| 10744 | | | | | CERTIFICATE OF DEATH | | | | | 10745 | | | | |
| 1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL REISTERSTOWN c. LENGTH OF STAY IN 1b 1 Mo. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) BAUBLITZ RD. | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BAUBLITZ RD d. STREET ADDRESS OWINGS MILLS. P.O. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First STANLEY Middle D Last RYAN | | | | | 4. DATE OF DEATH Month Aug. Day 26 Year 1967 | | | | | | | | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8 APRIL 1899 | | 9. AGE (In years last birthday) 68 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FORGING | | | | 10b. KIND OF BUSINESS OR INDUSTRY NOT A BOLT | | 11. BIRTHPLACE (County & State, or foreign country) BALTIMORE Co. Md. | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME DANIEL M. RYAN | | | | | 14. MOTHER'S MAIDEN NAME MAGGIE BOND | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. 213 10 1835 | | 17. INFORMANT THOMAS E. RYAN | | Address BAUBLITZ RD | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon 1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 mo | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. none p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 8-25-67 , 19____, to 8-26-67 , 19____, that (I) (was) last saw the deceased alive on 8-25-67 , 19____, and that death occurred at 5 AM , from the causes and on the date stated above. | | | | | | | | | | | | | | |
| 22a. SIGNATURE D. D. Caples | | | | | | | | | | 22b. DATE SIGNED 8-28-67 | | | | |
| 22c. PHYSICIAN'S NAME (Type) D. D. Caples, M. D. | | | | | 22d. ADDRESS 6 Hanover Rd., Reisterstown, Md. 21136 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE THEREOF 29 AUG 67 | | 23c. NAME OF CEMETERY OR CREMATORY WOODLAWN | | | | 23d. LOCATION (City, town or county) (State) BALTIMORE Co. Md. | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS BURGER FUNERAL HOME 3631 FALLS RD William R Kleiber | | | | | 25a. REC'D BY REGISTRAR AUG 30 1967 | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

It.ms 15-21 Film 392
9-14-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| 10745 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | 10746 | |
|---|---------------------------------|---|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk | | | 2 USUAL RESIDENCE (Where deceased lived f institution Residence before adm ssion) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Baltimore | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 849 Loalan Ave. | | | d. STREET ADDRESS 849 Loalan Ave. | | |
| 3 NAME OF DECEASED (Type or print) WILLIAM J. RYTINA | | | 4 DATE OF DEATH Month August Day 28 Year 19 67 | | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | 8 DATE OF BIRTH Aug 5, 1935 | 9 AGE (n years lost birthday) 32 yrs | 10 UNDER 1 YEAR Months 1 Days 19 Hours 67 Min |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Display man | | 10b KIND OF BUSINESS OR INDUSTRY Seas Co. | | 11 BIRTHPLACE (State or foreign country) Maryland | |
| 13 FATHER'S NAME James F. RYTINA | | | 14 MOTHER'S MAIDEN NAME Mary W. Jones | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of serv ice) no | | 16 SOCIAL SECURITY NO 213-32-8159 | | 17 INFORMANT James F. Rytina Address 849 Loalan Ave | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Combination overdose of Doriden, DUE TO 971.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Barbiturate and alcohol DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Subject committed suicide | | | |
| 20c TIME OF INJURY Month, Day Year Hour a.m. ? p.m. ? 19 | | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work | 20e PLACE OF INJURY (Home farm factory, street, office bldg, etc.) ? | 20f (City or town) ? | (County) ? (State) ? |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Russell S. Fisher | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22. DATE SIGNED August 28 | |
| EXAMINER'S NAME (Type) Russell S. Fisher, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 9-1-67 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | |
| 23d. LOCATION (City or Town) Baltimore, Md. | | 23e. LOCATION (County) Calvert | | 23f. LOCATION (State) Md. | |
| 24 FUNERAL DIRECTOR Philip E. Crach | | ADDRESS 1211 Chestnut Ave. | | 25a REC'D BY REGISTRAR SEP 5 1967 | |
| 25b REGISTRAR'S SIGNATURE Charles Judge | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|-------------------|--|--|---|--|---|---------------------------------|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown c. LENGTH OF STAY IN 1b 10746 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8823 Liberty Road | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown d. STREET ADDRESS 8823 Liberty Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) Mamie | | | First Middle Last | | | 4. DATE OF DEATH August 14 1967 | | | Month Day Year | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH January 9, 1892 | | 9. AGE (In years last birthday) 75 yrs. | | IF UNDER 1 YEAR Months Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Lassner | | | | | | 14. MOTHER'S MAIDEN NAME Minnie Gebhart | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO. 216-07-3698 | | 17. INFORMANT Address Miss Bessie E. Holtman 8823 Liberty Rd. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO ASCVD Conditions, if any, which gave rise to immediate cause (b) ASCVD (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lymphosarcoma of bone. | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/2 1966 to 6/26 1967 , the (II) (we) last saw the deceased alive on 6/26/66 , and that death occurred at .. M, from the causes and on the date stated above | | | | | | | | | | | |
| 22a. SIGNATURE John Darrell M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED 8/15/67 | | |
| 22c. PHYSICIAN'S NAME (Type) Dr. John J. Darrell | | | | | | 22d. ADDRESS 9017 Liberty Road Randallstown, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/16/67 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore | | 23d. LOCATION (City, town or county) (State) Baltimore Maryland | | 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Loring Byers 8728 Liberty Road Randallstown Md. | | | |
| 25a. REC'D BY REGISTRAR AUG 17 1967 | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 10747 | | | | | | 10748 | | | | | |
| 1. PLACE OF DEATH | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) | | | | | |
| a. COUNTY | | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | e. STATE | | | b. COUNTY | | |
| BALTO CO | | | KINGSVILLE | | | MD | | | BALTO | | |
| c. LENGTH OF STAY (In 15) | | | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | e. IS RESIDENCE ON A FARM? | | |
| | | | as his home Jerusalem Rd. | | | Kingsville | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | | First Middle Last | | | 4. DATE OF DEATH | | | Month Day Year | | |
| Thurman Carroll Sanders | | | | | | Aug 4 | | | 1967 | | |
| 5. SEX | | | 6. COLOR OR RACE | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH | | |
| Male | | | White | | | | | | Aug 2, 1892 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (County & State, or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Painter | | | Glen Martin Lancaster | | | Virginia | | | US | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | | | | | | | |
| Geo. W. Sanders | | | Catharine Dyke | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. (If yes give year or dates of service) | | | 17. INFORMANT | | | Address | | |
| no | | | 413-03-6843 | | | Amjette M Replunge | | | Kingsville Md | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) mesenteric Thrombosis | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (b) coronary Insufficiency | | | | | | | | | | | |
| (c) Arterio sclerosis | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | | | | |
| Chronic Bronchitis | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | | | | | | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1958 to Aug 4, 1967, that (I) (we) last saw the deceased alive on Aug 4, 1967, and that death occurred at M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE William H. Tyson M.D. | | | | | | | | | | | |
| 22b. DATE SIGNED | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) William H. Tyson | | | | | | | | | | | |
| 22d. ADDRESS Kingsville Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | | |
| 23b. DATE THEREOF Aug 7, 1967 | | | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith | | | | | | | | | | | |
| 23d. LOCATION (City, town or county) (State) Overlea Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE W. H. Archer | | | | | | | | | | | |
| 25a. REC'D BY REGISTRAR | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE Charles Yager | | | | | | | | | | | |

CERTIFICATE OF DEATH

10749

10749

| | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Joseph's Hospital | | c. LENGTH OF STAY IN 1b St. Joseph's Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | | b. COUNTY Baltimore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | d. STREET ADDRESS 121 Greenbrier Rd. #21204 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Dewey C. Santa | | 4. DATE OF DEATH Month August Day 29 Year 1967 | | 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH January 5, 1914 | | 9. AGE (In years last birthday) 53 | | 10. IF UNDER 1 YEAR Months 29 Days 19 Hours 67 Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electric welder | | 10b. KIND OF BUSINESS OR IND. STRY Grinnell Co. | | 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania | | 12. CIT. ZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Angelio Santa | | 14. MOTHER'S MAIDEN NAME Sue Varrato | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) None | | 16. SOCIAL SECURITY NO 216-01-3766 | |
| 17. INFORMANT Family records | | Address | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ruptured dissecting aneurysm 451X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease (c) | | INTERVAL BETWEEN ONSET AND DEATH | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that he (this hospital) attended the deceased from August 17, 1967 , to August 29, 1967 , that he (we) last saw the deceased alive on August 29, 1967 , and that death occurred at 12:40 AM from causes and on the date stated above. | | 22a. SIGNATURE Lawrence F. Misanik, M.D. | | 22b. DATE SIGNED August 29, 1967 | | 22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D. | | 22d. ADDRESS 7620 York Rd. Towson, Md. 21204 | | 22e. REC'D BY REGISTRAR SEP 5 1967 | | 22f. REGISTRAR'S SIGNATURE Charles J. Jones | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Aug. 31, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Foreland Memorial Park | | 23d. LOCATION (City or Town) (County) (State) Harville, Maryland | | 24. FUNERAL DIRECTOR John B. ... | | ADDRESS 613-613 York | | 25a. REC'D BY REGISTRAR SEP 5 1967 | | 25b. REGISTRAR'S SIGNATURE Charles J. Jones | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10748

CERTIFICATE OF DEATH

10750

| | | | |
|--|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | d. STREET ADDRESS 1706 Weston Ave. #21234 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) Francis J. Scally | | 4. DATE OF DEATH Month August Day 11 Year 1967 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 3, 1916 |
| 9. AGE (In years last birthday) 51 yrs | | IF UNDER 1 YEAR Months 11 Days 19 Hours 67 Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of last year) Public Works Supervisor | | 10b. KIND OF BUSINESS OR INDUSTRY Balto. Gas & Elec. | |
| 11 BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Francis J. Scally | | 14. MOTHER'S MAIDEN NAME Eileen T. Flynn | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWII | | 16. SOCIAL SECURITY NO. 214 03 1700 | |
| 17. INFORMANT Margaret Scally | | Address 1706 Weston Av. Balto Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Acute Pulmonary edema DUE TO (c) | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from August 10, 1967 , to August 11, 1967 , that (I) (we) last saw the deceased alive on August 11, 1967 , and that death occurred at 6:00AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Jaime Singzon</i> | | 22b. DATE SIGNED August 11, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Jaime Singzon, M.D. | | 22d. ADDRESS 7620 York Road #21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 11-14-67 | 23c. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem. | 23d. LOCATION (City or Town) (County) (State) Balto. Md. |
| 24. FUNERAL DIRECTOR Wm. E. Johnson. 8521 Loch Raven Blvd. Balto. | | 25a. REC'D BY REG. STR. AUG 15 1967 25b. REG. STR. SIGNATURE <i>George</i> | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10750

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10751

| | | | |
|---|---|---|---|
| 1 PLACE OF DEATH a COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Balto. | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebbville | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Balto. Co. General Hospital | | d STREET ADDRESS 2701 Rolling Road Balto 7, Md | |
| 3 NAME OF DECEASED (Type or print) MORGAN, L. Schisler | | 4 DATE OF DEATH Month 8 Day 6 Year 1967 | |
| 5 SEX m | 6 COLOR OR RACE W | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 12/23/00 9 AGE (In years last birthday) 66 yrs |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer | | 10b KIND OF BUSINESS OR INDUSTRY Home Bldg. | |
| 11 BIRTHPLACE (State or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME John H. Schisler | | 14 MOTHER'S MAIDEN NAME Daisy M. Bush | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16 SOCIAL SECURITY NO 218-12-8369 | |
| 17 INFORMANT Mrs. Eunice Schisler | | Address 2701 Rolling Rd. Md. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 4201 IMMEDIATE CAUSE (a) Coronary Occlusion Sudden DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour am 19 pm | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles F. O'Donnell | | 22. DATE SIGNED 8/6/67 | |
| EXAMINER'S NAME (Type) Charles. F. O'Donnell, M.D. | | Address (Street, city, town or county) | |
| 23a BURIAL, CREMATION REMOVAL (Specify) Burial | 23b DATE THEREOF 8/9/67 | 23c NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery | 23d LOCATION (City or town) (County) (State) Woodlawn Balto Co Md. |
| 24 FUNERAL DIRECTOR Loring Byers | | 25a REC'D BY REGISTRAR AUG 10 1967 | |
| ADDRESS 8728 Liberty Rd Randallstown Md | | 25b REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

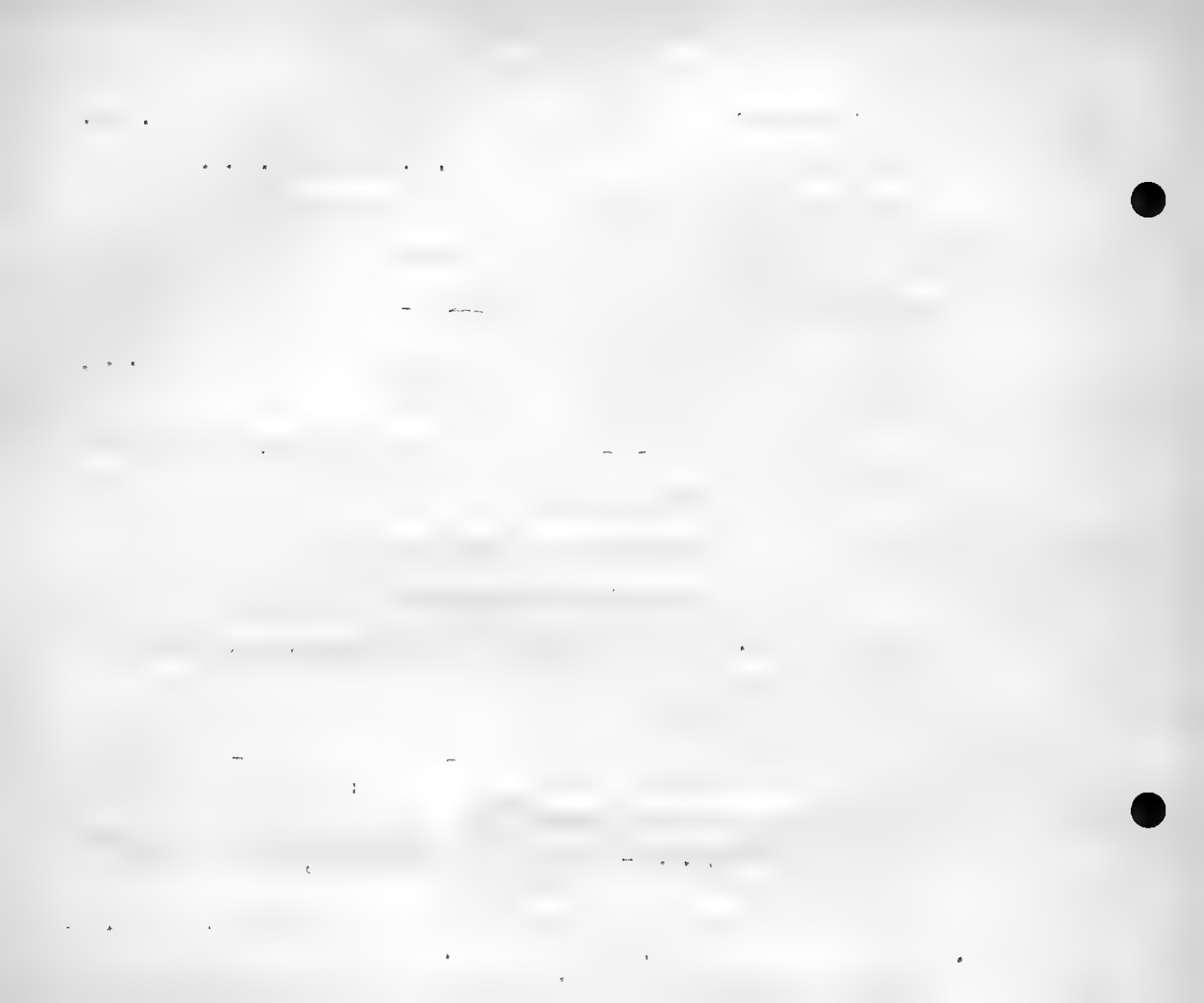
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10751

CERTIFICATE OF DEATH

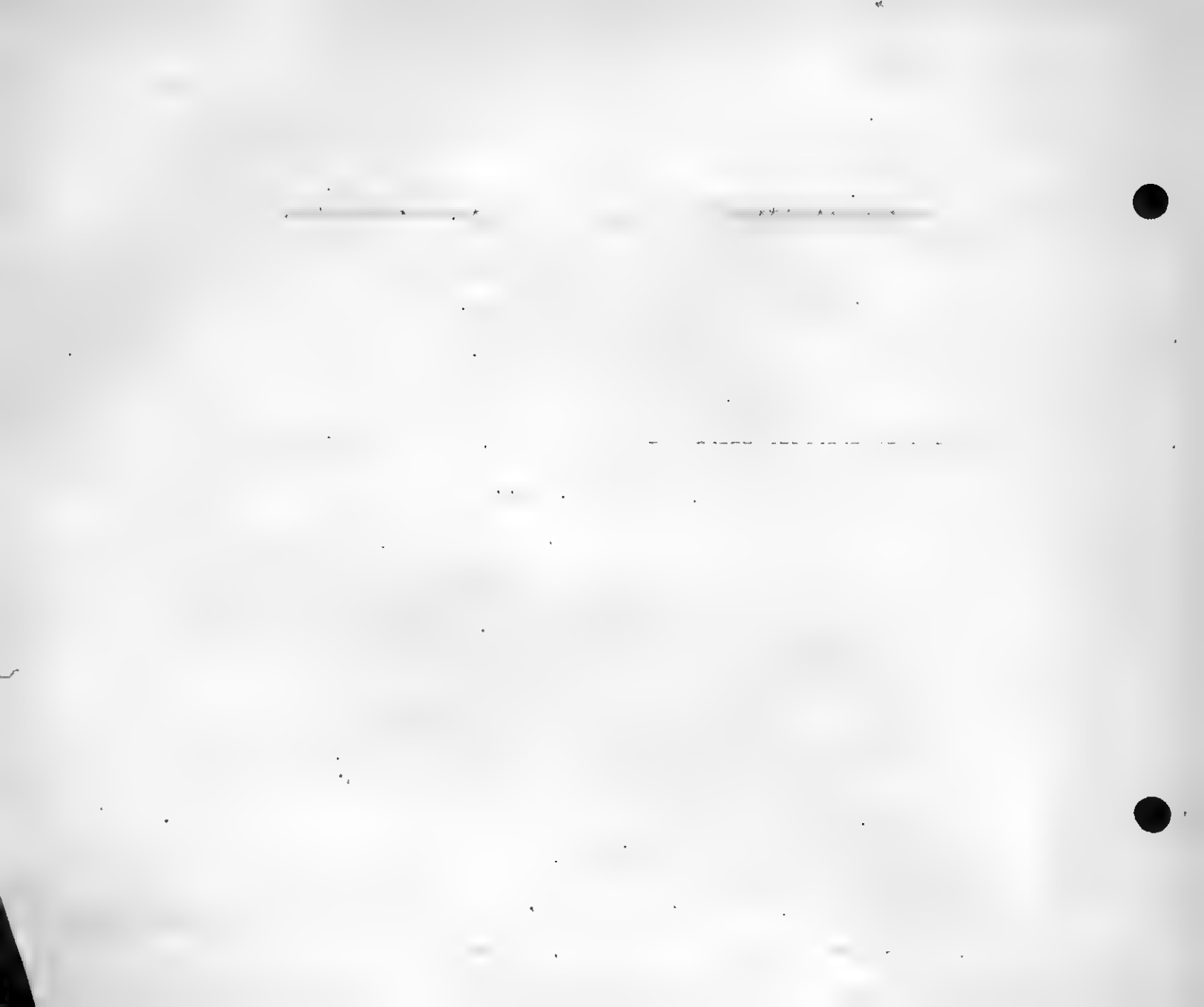
10752

| | | | |
|--|-------------------------------------|---|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Pr. Geo. | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c LENGTH OF STAY IN 1b S. E. Washington, D.C. | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital | | d STREET ADDRESS 5111 Alton Street | |
| 3 NAME OF DECEASED (Type or print) Marie | | 4. DATE OF DEATH Month 8 Day 5 Year 67 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-28-13-94 |
| 9 AGE (In years lost birthday) yrs. 73 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Rafferty | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16 SOCIAL SECURITY NO 579-66-0380 | |
| 17. INFORMANT Records: Spring Grove State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urinary Infection.-Several decubital ulcers(back,sacrum,hips,elbows) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) none | | 20c. TIME OF INJURY Month, Day, Year Hour o.m. none 19 | |
| 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from 5-5 , 19 66 , to 8-5 , 19 67 , that (I) (we) last saw the deceased alive on August 5 19 67 , and that death occurred at 7:15P M, from causes and on the date stated above. | |
| 22a. SIGNATURE Imre KOPITS, M.D. | | 22b. DATE SIGNED 8/5/67 | |
| 22c. PHYSICIAN'S NAME (Type) Imre KOPITS, M.D. (K-7077) | | 22d. ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b DATE THEREOF 8/9/1967 | 23c NAME OF CEMETERY OR CREMATORY Moreland Memorial | 23d. LOCATION (City or Town) (County) (State) Parkville, Balto. Co., Md |
| 24. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md. | | 25a. REC'D BY REGISTRAR AUG 7 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|----------------------------------|---|---|---|---|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 10752 CERTIFICATE OF DEATH 10753 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 21204 | | | | c. LENGTH OF STAY IN 1b years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 21204 | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 905 Breezewick Road | | | | | d. STREET ADDRESS 905 Breezewick Road | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MIDDLE Last WYATT SCHOONMAKER | | | 4. DATE OF DEATH August 26, 1967 | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Aug. 16, 1901 | | 9. AGE (In years last birthday) 66 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager | | | | 10b. KIND OF BUSINESS OR INDUSTRY Titanium Pigment Co. | | 11. BIRTHPLACE (County & State, or foreign country) Maine | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Nathan Wyatt Schoonmaker | | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Skinner | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch of service) No | | | | 16. SOCIAL SECURITY NO. 084-01-7877 | | 17. INFORMANT Mrs. Ruth Schoonmaker, Same as # 2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive a.s.c.v.d. DUE TO (c) Diabetes Mellitus | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 weeks + several yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Asthmatic Bronchitis | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov 1963 to Aug 26, 1967 , that (I) (we) last saw the deceased alive on Aug 25, 1967 , and that death occurred at 8 A.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Samuel Morrison | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 8/26/67 | | |
| 22c. PHYSICIAN'S NAME (Type) SAMUEL MORRISON | | | | | 22d. ADDRESS 11 E. Chase St. 21202 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE THEREOF Aug. 29, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery | | 23d. LOCATION (City, town or county) (State) Cockeysville, Maryland | | |
| 24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Rd. Towson, Md | | | | | 25. REC'D BY REGISTRAR AUG 29 1967 | | 25d. REGISTRAR'S SIGNATURE [Signature] | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10753

10754

| | | | | | | | |
|--|----------------------------------|--|------------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> | | c. LENGTH OF STAY IN lb <u>11 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1413 Sulphur Spring Rd.</u> | | | | d. STREET ADDRESS <u>1413 Sulphur Spring Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Ida Schrage</u> | | | | 4. DATE OF DEATH Month <u>August</u> Day <u>26</u> Year <u>1967</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/16/07</u> | 9. AGE (in years lost birthday) <u>60</u> yrs. | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | | 11. IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Business Mach.</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William Schrage</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Marie Schneider</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>215-07-5732</u> | | 17. INFORMANT Address <u>Anna Morgan 1413 Sulphur Sp. Rd.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory and cardiac arrest</u> DUE TO <u>1810</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Carcinomatosis secondary to carcinoma of urinary bladder</u> DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>4 months</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (do not know) attended the deceased from <u>Nov. 16, 1966</u> to <u>Aug. 26, 1967</u> , that (I) (we) saw the deceased alive on <u>July 29, 1967</u> , and that death occurred at <u>1 a.m.</u> from causes on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>S. J. Liu</u> | | | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED <u>Aug. 26, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>S. J. Liu, M. D.</u> | | | | 22d. ADDRESS <u>5301 Harford Rd. Balto., Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>8/29/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cemetery Baltimore Maryland</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>Amber Du-1328 Sulphur Sp. Rd.</u> | | | | 25a. REG'D BY REGISTRAR DATE <u>AUG 29 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



10754

10755

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|-------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY B | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN It Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House In The Pines | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Frieda A. Schwanebeck | | 4. DATE OF DEATH August 10 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/7/93 |
| 9. AGE (In years last birthday) 74 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | |
| 11. BIRTHPLACE (County & State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Frederick Schwanebeck | | 14. MOTHER'S MAIDEN NAME Martha Kietzler | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. 215-01-0746 | |
| 17. INFORMANT Mr. Harry F. Schwanebeck | | Address 4300 Wilkens Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic C.V. Disease DUE TO Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH 10 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June , 19 57 , to Aug 10 , 19 67 , that (I) (we) last saw the deceased alive on Aug 4 , 19 67 , and that death occurred at _____ M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE John F. Coolahan | | 22b. DATE SIGNED 8/11/67 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. John Coolahan | | 22d. ADDRESS 4201 Wilkens Ave. | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/12/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Kx Loudon Park Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore Md. | |
| 24. FUNERAL DIRECTOR Howard H. Hubbard | | 25a. REC'D BY REGISTRAR AUG 14 1967 | |
| ADDRESS 4107 Wilkens Ave. 21229 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10755

10756

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form S may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|---|--|---|---|---|--|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Edgemere | | c. LENGTH OF STAY IN It 25 Years | | 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Edgemere | | d. STREET ADDRESS 6702 Old North Point Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) Leroy Stewart Scott | | | 4 DATE OF DEATH Month August Day 15 Year 1967 | | | 5 SEX Male | | 6 COLOR OR RACE White | |
| 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH March 3, 1906 | | 9 AGE (in years last birthday) yrs 61 | | 10 UNDER 1 YEAR Months 15 Days 15 | | 11 UNDER 24 HRS Hours 15 Min 15 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Mill | | 10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co. | | 11 BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13 FATHER'S NAME William Scott | | | 14. MOTHER'S M.A.DEN NAME Amanda Jane Scott | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | |
| 16 SOC. A. SECURITY NO. 213-07-7654 | | 17 INFORMANT (Daughter) Arlene Scott, 6702 Old North Point Rd. | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) A-S-C-V-Disease DUE TO (c) Diabetes Mellitus | | | |
| 19. INTERVAL BETWEEN ONSET AND DEATH 4201 | | 20. PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus | | | | 21. WAS A T.O.P.S.V. PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part I of item 18) | | | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home form factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| 22. ACTUAL SIGNATURE M. B. Davis | | 23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 24. DATE SIGNED 8/16/67 | | 25. ADDRESS (Street city town, or county) Dundalk, Md. 21222 | | | |
| 25a. B. RIAL CREMATION REMOVAL (Specify) Burial | | 25b. DATE THEREOF 8/17/67 | | 25c. NAME OF CEMETERY OR CREMATORY Unionville Cemetery | | 25d. LOCATION (City or town) (County) (State) Unionville, Pennsylvania | | | |
| 26. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md. | | 27. REC'D BY REGISTRAR AUG 18 1967 | | 28. REGISTRAR'S SIGNATURE Charles J. J... | | | | | |



10756

CERTIFICATE OF DEATH

10757

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN TB 16 days | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) City d. STREET ADDRESS 2621 W. Cold Spring Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Raleigh Scott | | 4. DATE OF DEATH Month Day Year August 18 1967 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-5-29 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 37 yrs |
| 11. BIRTHPLACE (County & State, or foreign country) S. Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Scott | | 14. MOTHER'S MAIDEN NAME Jannine Woods | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO 246-42-1638 | |
| 17. INFORMANT Records, Mount Wilson State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cor. Pulmonalis 5-18 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic obstructive airway disease DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Tuberculosis | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 8-2 , 19 67 , to 8-18 , 19 67 that (I) (we) last saw the deceased alive on 8-18 , 19 67 , and that death occurred at 12:58 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE W. Newcomer | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent Mount Wilson, Maryland | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/22/67 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn | 23d. LOCATION (City or Town) (County) (State) Baltimore Md. |
| 24. FUNERAL DIRECTOR Phillips Funeral Home | | 25a. REC'D BY REGISTRAR AUG 23 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

$$\begin{array}{r} 82 \\ \hline 64 \\ 18 \end{array}$$

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
GM 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10758

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | c. LENGTH OF STAY in 1b 37 yrs. | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hammonds Ferry & Sulphur Spring Road | | | | e. STREET ADDRESS 340 5th Avenue | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) SAMUEL TELGHMAN SEYMOUR | | 4. DATE OF DEATH Month August Day 4 Year 19 67 | | 5 SEX Male | | 6 COLOR OR RACE White | |
| 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH 9-14-1876 | | 9 AGE (In years last birthday) 70 yrs | | 10 UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Account | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Samuel J. Seymour | | | | 14. MOTHER'S MAIDEN NAME Mar. R. Twilley | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes | | 16. SOCIAL SECURITY NO. W. 11.1 | | 17. INFORMANT John R. Seymour | | Address 340 5th Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY Multiple Injuries IMMEDIATE CAUSE (a) Multiple Injuries DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Subj. was pedestrian crossing RR Tracks - was struck by locomotive | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 6:30 pm 8 4 1967 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RR Tracks | | 20f. (City or town) (County) (State) Baltimore, Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Werner U. Spitz | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED 8/4/67 | |
| EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8-1-67 | | 23c. NAME OF CEMETERY OR CREMATORY Woodridge Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | |
| 24. FUNERAL DIRECTOR Abrose Funeral Home | | | | ADDRESS 1000 Sulphur Sp. | | 25a. REC'D BY REGISTRAR AUG 7 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | |
|--|------------------------------|---|--------------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | |
| 10758 | | CERTIFICATE OF DEATH | | 10759 | |
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u> | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | c LENGTH OF STAY IN 1b | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7801 Ridge Terrace #8</u> | | d. STREET ADDRESS <u>7801 Ridge Terrace #8</u> | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Solomon (Sol) Shaivitz</u> | | 4 DATE OF DEATH <u>August 22, 1967</u> | | Month Day Year | |
| 5 SEX <u>Male</u> | 6 COLOR OR RACE <u>White</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>Feb. 22, 1898</u> | 9 AGE (In years last birthday) <u>69</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Furniture</u> | | 10b KIND OF BUSINESS OR INDUSTRY <u>Executive</u> | | 11 BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Moses Shaivitz</u> | | 14. MOTHER'S MAIDEN NAME <u>Rose Rabinowitz</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes (W. W. I Army)</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Mrs. Rose Shaivitz, 7801 Ridge Terrace #8</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma - Signed</u> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/7/67</u> , 19 <u>67</u> , to <u>8/22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/16</u> , 19 <u>67</u> , and that death occurred at <u>7 P.M.</u> from causes and on the date stated above | | | | | |
| 22a SIGNATURE <u>Barnett Berman, M.D.</u> | | 22b. DATE SIGNED <u>8/23/67</u> | | 22c. PHYSICIAN'S NAME (Type) <u>Barnett Berman</u> | |
| 22d ADDRESS <u>611 Park Avenue</u> | | 22e MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b DATE THEREOF <u>8/23/67</u> | | 23c NAME OF CEMETERY OR CREMATORY <u>Beth Tfiloh</u> | |
| 23d LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u> | | 25a REC'D BY REGISTRAR <u>AUG 25 1967</u> | | 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

2. 10. 1941



1. 10. 1941

10758

CERTIFICATE OF DEATH

10760

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u> Md </u> b COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | c. LENGTH OF STAY IN 1b <u>Baltimore</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>734 Warwick Road</u> | | a STREET ADDRESS <u>734 Warwick Road</u> | |
| 3 NAME OF DECEASED (Type or print) <u>Edward P. Shanahan</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>19</u> Year <u>1967</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 5, 1903</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trust Officer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>1st National Bank</u> | 9. AGE (In years last birthday) <u>63</u> yrs |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Edward P. Shanahan</u> | | 14. MOTHER'S MAIDEN NAME <u>Theresa McQuirk</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO <u>21229</u> | |
| 17. INFORMANT <u>Mrs. Lourdean M. Shanahan, 734 Warwick Rd.</u> | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral embolism - Heart Failure</u> DUE TO (b) <u>ASCVD.</u> DUE TO (c) <u>Bleeding ulcer.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH <u>5-6</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cerebral embolism</u> | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21 I certify that (I) (this hospital) attended the deceased from <u>Sept 1963</u> , to <u>Aug 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>19</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Richard M. Susel</u> | | 22b. DATE SIGNED <u>August 19, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Richard M. SUSSEL</u> | | 22d. ADDRESS <u>4001 Wilkens Avenue</u> | |
| 23a BURIAL, CREMATION, REMOVAL <u>BURIAL</u> | 23b. DATE THEREOF <u>8-22-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u> | | 25a. REC'D BY REGISTRAR DATE <u>AUG 22 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10760

CERTIFICATE OF DEATH

10761

| | | | |
|---|---|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u></u> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowson</u> | | c LENGTH OF STAY IN 1b <u></u> | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pickersgill</u> | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) <u>Edith Shooly</u> | | 4 DATE OF DEATH Month <u>August</u> Day <u>19</u> Year <u>1967</u> | |
| 5 SEX <u>F</u> | 6 COLOR OR RACE <u>W</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>May 4, 1881</u> |
| 9 AGE (in years, last birthday) <u>86</u> yrs. | | 10 F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> | |
| 11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cannasser</u> | | 11b KIND OF BUSINESS OR INDUSTRY <u></u> | |
| 12 BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md</u> | | 13 CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 14 FATHER'S NAME <u>James C Shooly</u> | | 15 MOTHER'S MAIDEN NAME <u>Mary Fredrick</u> | |
| 16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 17 SOCIAL SECURITY NO. <u>215-54-1671</u> | |
| 18 INFORMANT <u>A. Marie Weaver R.N.</u> | | Address <u></u> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO (b) <u>ASCVD</u> DUE TO (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u> | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21 I certify that (I) (this hospital) attended the deceased from <u>August 19, 1967</u> to <u>August 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>August 19, 1967</u> , and that death occurred at <u>4:20 P.M.</u> from causes and on the date stated above. | | | |
| 22a SIGNATURE <u>Newland Edward Day</u> MD | | 22b. DATE SIGNED <u>August 19, 1967</u> | |
| 22c PHYSICIAN'S NAME (Type) <u>Newland E. Day MD</u> | | 22d. ADDRESS <u>4-E-33rd St Balto. Md.</u> | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Aug 22, 67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md</u> |
| 24 FUNERAL DIRECTOR <u>Wm Cook-Brooks Townson</u> | | 25a REC'D BY REGISTRAR <u>Charles Judge</u> | |
| ADDRESS <u>1050 York Rd</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE <u>UG 24 1967</u> | | | |

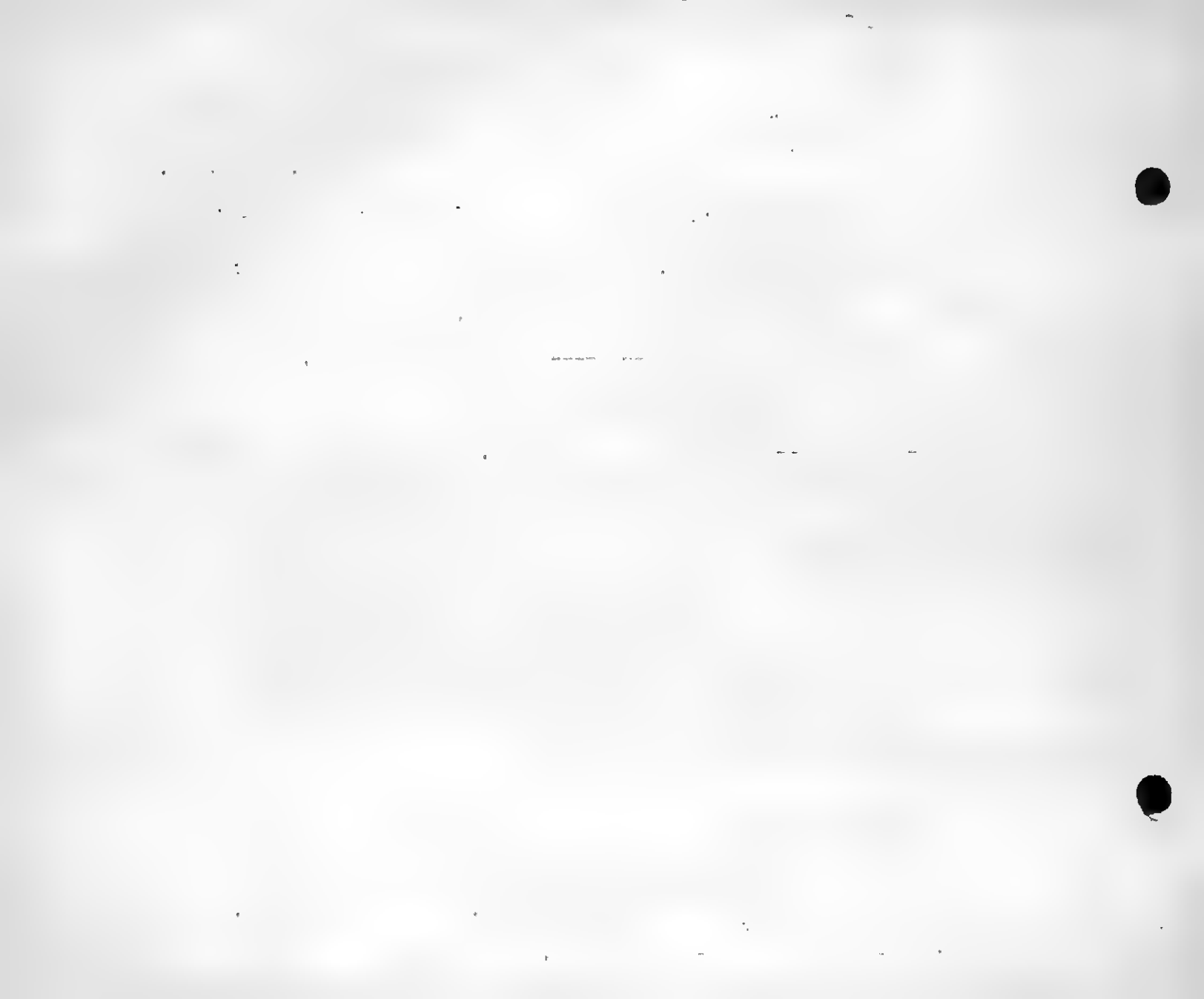
21204

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| <div> <div>1</div> <div> <div>10761</div> <div>10762</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div> | | | | | | | | | |
|---|----------------------------------|--|--|--|--|---|-----------------------------|------------------------------------|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | c. LENGTH OF STAY IN 1b Rodgers Forge, Balto. Co. | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7028 Heathfield Road | | | | | d. STREET ADDRESS 7028 Heathfield Rd-12 | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last ANITA M. SHEESLEY | | 4. DATE OF DEATH Month Day Year August 28th 1967 | | | | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 14, 1868 | | 9. AGE (In years last birthday) 99 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME DANIEL SHEESLEY | | | | 14. MOTHER'S MAIDEN NAME MARY TWOHEY | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) no- | | 16. SOCIAL SECURITY NO. -- | | 17. INFORMANT Mrs. Virginia Hartis- | | Address Same | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe myocardial changes DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- DUE TO (c) --- | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from --- , 19 57 , to Aug. 27 , 19 67 , that (I) (we) last saw the deceased alive on Aug. 27 , 19 67 , and that death occurred at 5 P. M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE J. Willis Guyton | | | | | | | | 22b. DATE SIGNED 8/29/67 | |
| 22c. PHYSICIAN'S NAME (Type) J. Willis Guyton M.D. | | | | 22d. ADDRESS 3961 Greenmount Ave. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/31/67 | | 23c. NAME OF CEMETERY OR CREMATORY Cathedral Cem. | | 23d. LOCATION (City, town or county) (State) Balto. | | | |
| 24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home-6500 York Rd. 21212 | | | | 25a. REC'D BY REGISTRAR SEP 1 1967 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and information within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10762

CERTIFICATE OF DEATH

10763

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore Md 21204 MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center | | e. STREET ADDRESS 6201 N. York Rd. 414 Dumbarton Rd. | |
| 3. NAME OF DECEASED (Type or print) First Robert Middle Mary Last Vick Shenton | | 4. DATE OF DEATH Month Aug. Day 6 Year 1967 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/29/04 |
| 9. AGE (In years lost birthday) 62 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Housekeeper | |
| 11. BIRTHPLACE (County & State, or foreign country) Jonesborough, N.C. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Alexander Vick | | 14. MOTHER'S MAIDEN NAME Stella Currie | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO 215-22-2429 | |
| 17. INFORMANT Mr. Richard C. Shenton | | Address Same | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 8/6/67 , 19 to 8/6, 1967 , that (I) (we) last saw the deceased alive on 8/6/1967 , and that death occurred at 6:25 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Nasser Eftekhari | | 22b. DATE SIGNED 8/6/67 | |
| 22c. PHYSICIAN'S NAME (Type) Nasser Eftekhari | | 22d. ADDRESS GBMG | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8-9-67 | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn | 23d. LOCATION (City or Town) (County) (State) Woodlawn, Md. |
| 24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. 6500 York Rd. | | 25a. REC'D BY REGISTRAR AUG 9 1967 | |
| ADDRESS | | REGISTERED SIGNATURE Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10763

CERTIFICATE OF DEATH

10763

| | | | |
|---|---------------------------------|--|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY _____ | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c LENGTH OF STAY IN tb 6 weeks | |
| c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 21223 | | d STREET ADDRESS 342 S. Bentaloue St. | |
| a NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Augusta E. Shipley | | 4 DATE OF DEATH Month Day Year 7 19 1967 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Jan. 20, 1906 |
| 9 AGE (In years lost birthday) yrs 61 | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10b KIND OF BUSINESS OR INDUSTRY DOMESTIC | |
| 11 BIRTHPLACE (County & State or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? U.S. | |
| 13 FATHER'S NAME Christopher Lang | | 14 MOTHER'S MAIDEN NAME Margaret Dorch | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO NONE | | 16. SOCIAL SECURITY NO. 219-30-5587 | |
| 17. INFORMANT Records: Spring Grove State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO (b) Shock DUE TO (c) possible myo. heart in in | | INTERVAL BETWEEN ONSET-AND DEATH 1-2 hrs 4 hrs | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 19, 1967 , to July 19, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7/20 1967 , and that death occurred at 4:30 AM , from causes and on the date stated above | | | |
| 22a SIGNATURE Am-Lowen | | 22b DATE SIGNED 5/20/67 | |
| 22c PHYSICIAN'S NAME (Type) Am-Lowen | | 22d ADDRESS Spring Grove State Hospital Baltimore, Maryland 21228 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE THEREOF 8-29-67 | |
| 23c NAME OF CEMETERY OR CREMATORY SMITH FAMILY | | 23d LOCATION (City or Town) (County) (State) SEVERN A.A. Md. | |
| 24 FUNERAL DIRECTOR Francis H. Miller 2101 Frederick Ave | | 25a REC'D BY REGISTRAR AUG 29 1967 | |
| 25b REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| 1. PLACE OF DEATH | | | | | | | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) | | | | | | | | | | | |
|--|--|--|--|--|--|-----------|--|--|--|--|--|--|--|--|--|--|--|----------|--|--|--|--|--|
| a. COUNTY | | | | | | Baltimore | | | | | | a. STATE | | | | | | Maryland | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | | | | | | | b. COUNTY | | | | | | | | | | | |
| Reisterstown | | | | | | | | | | | | Baltimore | | | | | | | | | | | |
| c. LENGTH OF STAY IN 1b | | | | | | | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | | | | | | | | d. STREET ADDRESS | | | | | | | | | | | |
| 242 Walgrove Road | | | | | | | | | | | | 242 Walgrove Road | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | | | | | | | | | | 4. DATE OF DEATH | | | | | | | | | | | |
| Barbara D. Sizer | | | | | | | | | | | | August 27, 1967 | | | | | | | | | | | |
| 5. SEX | | | | | | | | | | | | 6. COLOR OR RACE | | | | | | | | | | | |
| Female | | | | | | | | | | | | White | | | | | | | | | | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | | | | | | | | | | 8. DATE OF BIRTH | | | | | | | | | | | |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | | | 2-2-1931 | | | | | | | | | | | |
| 9. AGE (In years last birthday) | | | | | | | | | | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | | | | | | | |
| 36 yrs. | | | | | | | | | | | | Legal Secretary | | | | | | | | | | | |
| 11. BIRTHPLACE (County & State, or foreign country) | | | | | | | | | | | | 12. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | | |
| Maryland | | | | | | | | | | | | U.S.A. | | | | | | | | | | | |
| 13. FATHER'S NAME | | | | | | | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Herbert Dennis | | | | | | | | | | | | Unknown | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | | | | | | | | 16. SOCIAL SECURITY NO. | | | | | | | | | | | |
| (If yes give war or dates of service) | | | | | | | | | | | | 218-28-7333 | | | | | | | | | | | |
| 17. INFORMANT | | | | | | | | | | | | Address | | | | | | | | | | | |
| Mr. Lewis W. Sizer, 242 Walgrove Rd. 21136 | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) CEREBRAL METASTASIS | | | | | | | | | | | | 18 HRS. | | | | | | | | | | | |
| DUE TO | | | | | | | | | | | | 2 YRS. | | | | | | | | | | | |
| (b) CARCINOMA BREAST | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? | | | | | | | | | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year | | | | | | | | | | | | 20d. INJURY OCCURRED | | | | | | | | | | | |
| Hour a.m. p.m. 19 | | | | | | | | | | | | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | | | | | 20f. (City or town) (County) (State) | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from JULY 23, 1967, to AUG. 27, 1967, that (I) (we) last saw the deceased alive on AUG. 26, 1967, and that death occurred at 7 A.M. from the causes and on the date stated above. | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE | | | | | | | | | | | | 22b. DATE SIGNED | | | | | | | | | | | |
| Martin E. Strubel | | | | | | | | | | | | 8/27/67 | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | | | | | | | | 22d. ADDRESS | | | | | | | | | | | |
| MARTIN E. STRUBEL | | | | | | | | | | | | REISTERSTOWN, MD. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | | | 23b. DATE THEREOF | | | | | | | | | | | |
| BURIAL | | | | | | | | | | | | 8-30-1967 | | | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | | | 23d. LOCATION (City, town or county) (State) | | | | | | | | | | | |
| Loudon Park Cemetery | | | | | | | | | | | | Baltimore, Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE | | | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | | |
| Howard H. Hubbard, 4107 Wilkens Avenue 21229 | | | | | | | | | | | | AUG 29 1967 | | | | | | | | | | | |
| | | | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| | | | | | | | | | | | | Charles Judge | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10765

CERTIFICATE OF DEATH

10766

| | | | | | | | |
|--|------------------------------|---|------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> | | c. LENGTH OF STAY IN TB <u>15 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Spring Grove State</u> | | | | d. STREET ADDRESS <u>Obrecht Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>ARRINGTON</u> Last <u>SMITH</u> | | | | 4. DATE OF DEATH Month <u>8</u> Day <u>12</u> Year <u>1967</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-31-95</u> | | 9. AGE (In years last birthday) <u>72</u> yrs | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Woodsboro, MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Phillip Smith</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah Arrington</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>217-36-4608</u> | | 17. INFORMANT <u>Mrs B Mans</u> Address <u>53, Springfield Ave., Sykesville 21764</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>501X Asthmatic Bronchitis</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 28, 1967</u> , to <u>Aug. 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug. 12, 1967</u> , and that death occurred at <u>6:45 P.M.</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Robert E. Ludicke</u> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>Robert E. Ludicke</u> | | | | 22d. ADDRESS <u>Spring Grove Hospital - Catonsville, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>8-16-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Howard Co. Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Harry W. Knight</u> | | | | ADDRESS <u>Sykesville, Md.</u> | | 25a. RECEIVED BY REGISTRAR DATE <u>AUG 17 1967</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u> | | | |

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10766

CERTIFICATE OF DEATH

20787

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|-----------------------------------|--|---|
| 1 PLACE OF DEATH a. COUNTRY <u>DALTON, CO.</u> | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u> | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. EDMOND ALE 21229</u> | | c. LENGTH OF STAY IN 1b | | d. STREET ADDRESS <u>5431 CHANNING RD.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5431 CHANNING RD.</u> | | e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) <u>ORVILLE A. SMITH</u> | | 4 DATE OF DEATH Month <u>AUG</u> Day <u>3</u> Year <u>1967</u> | | | |
| 5 SEX <u>M</u> | 6 COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>8/11/13</u> | 9 AGE (In years lost birthday) yrs <u>53</u> | IF UNDER 1 YEAR Months <u>5</u> Days <u>13</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACH.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>BETH. STEEL CO.</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u> | |
| 13. FATHER'S NAME <u>PETER SMITH</u> | | 14. MOTHER'S MAIDEN NAME <u>ANNA REUSING</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO <u>214-01-5330</u> | | 17. INFORMANT <u>ANN L. SMITH</u> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the colon</u> 1551 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 <u>1967</u> | 20a. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) | 20f. (City or town) | (County) | (State) |
| 21 I certify that (I) (this hospital) attended the deceased from <u>January 1, 1964</u> , to <u>August 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 1, 1967</u> , and that death occurred at <u>SA, M.</u> from causes and on the date stated above | | | | | |
| 22a. SIGNATURE <u>Morris Steinberg</u> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>8/4/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>MORRIS STEINBERG</u> | | 22d. ADDRESS <u>3913 HOLLINS FERRY RD.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>8/5/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>CATHEDRAL</u> | | 23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD</u> | |
| 24 FUNERAL DIRECTOR <u>E. S. MALNAB</u> | | ADDRESS <u>301 FREDERICK RD 21228</u> | | 25a. REC'D BY REGISTRAR <u>AUG 7 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> |

10767

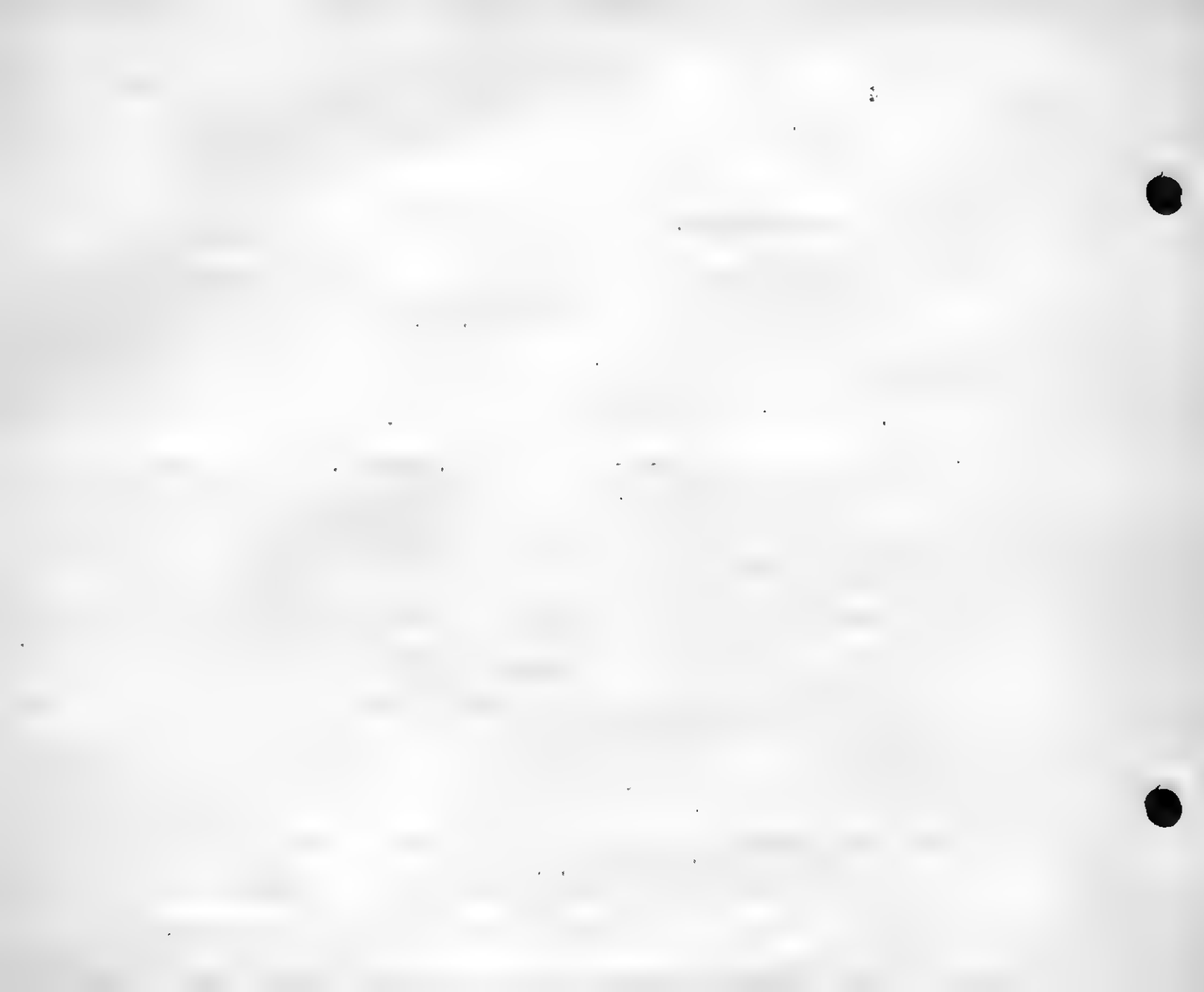
CERTIFICATE OF DEATH

10768

| | | | |
|---|---|--|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8131 Loch Raven Blvd. | | d. STREET ADDRESS 8131 Loch Raven Blvd. | |
| 3. NAME OF DECEASED (Type or print) ROBERT THOMAS SMITH | | 4. DATE OF DEATH August 5th, 1967 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 31, 1913 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor | | 10b. KIND OF BUSINESS OR INDUSTRY Balto City | 9. AGE (In years last birthday) 54 yrs |
| 11. BIRTHPLACE (County & State, or foreign country) Ohio | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Wm. Lewis Smith | | 14. MOTHER'S MAIDEN NAME Maude Parrish | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 299-01-3123 | 17. INFORMANT Mrs. Marie N. Smith Address same |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion Sudden DUE TO Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 3yr (b) 3yr (c) | | INTERVAL BETWEEN ONSET AND DEATH 3yr | |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 4, 1952 to Aug 5, 1967 , that (I) (we) last saw the deceased alive on 8/5/67 , and that death occurred at 9:20 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Charles F. O'Donnell M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED 8/8/67 |
| 22c. PHYSICIAN'S NAME (Type) Charles F. O'Donnell, M.D. | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/8/67 | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Park | 23d. LOCATION (City or Town) (County) (State) Balto Co. |
| 24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. 6500 York Road, 21212 | | 25a. REC'D BY REGISTRAR AUG 9 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10768

CERTIFICATE OF DEATH

10769

| | | | |
|--|--|--|---|
| 1 PLACE OF DEATH a COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson | | c. LENGTH OF STAY IN 1b 22 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital | | e. STREET ADDRESS 190 Clay Str. | |
| 3 NAME OF DECEASED (Type or print) EDWARD First SORRELL Middle LAST | | 4 DATE OF DEATH Month 8 Day 21 Year 1967 | |
| 5 SEX M | 6. COLOR OR RACE Negro | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3.18.1905 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator operator | | 10b. KIND OF BUSINESS OR INDUSTRY | 9 AGE (In years last birthday) 62 yrs |
| 11 BIRTHPLACE (County & State, or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13 FATHER'S NAME LOUIS SORRELL | | 14 MOTHER'S MAIDEN NAME JOSEPHINE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO 214-05-1554 | |
| 17 INFORMANT Records, Mt. Wilson State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of sigmoid colon. Emphysema | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 7.31.1967 to 8.21.1967 , that (I) (we) last saw the deceased alive on 8.21.1967 , and that death occurred at 2:40 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE Wm. Newcomer | | 22b. DATE SIGNED 8.21.1967 | |
| 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Supt. | | 22d. ADDRESS Mt. Wilson, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8-24-67 | 23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland |
| 24 FUNERAL DIRECTOR Charles R. Law 802 Madison Ave., Balto., Md. | | 25a. REC'D BY REGISTRAR DATE AUG 24 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10768
CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>73 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>7427 Harford Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>May</u> Middle <u>Mary</u> Last <u>Spuck</u> 4. DATE OF DEATH <u>8</u> <u>19</u> <u>1967</u> | | 5. SEX <u>F</u> 6. COLOR OR RACE <u>Can</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>12-31-93</u> 9. AGE (in years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Jerry (unknown)</u> 14. MOTHER'S MAIDEN NAME <u>Jane</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service) <u>—</u> 16. SOCIAL SECURITY NO. <u>213-34-637D</u> 17. INFORMANT <u>Jim</u> Address <u>Jane</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> DUE TO (b) <u>Severe anemia</u> DUE TO (c) <u>terminal ca of breast with metastasis to brain</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>—</u> p.m. <u>—</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3-29</u> , 19 <u>67</u> to <u>8-19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-19</u> , 19 <u>67</u> , and that death occurred at <u>5:15</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>P. Nandi</u> 22c. PHYSICIAN'S NAME (Type) <u>P. Nandi</u> | | 22b. DATE SIGNED <u>8-19-67</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| 22d. ADDRESS <u>—</u> | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 22 1967</u> 23b. DATE THEREOF <u>Aug 22 1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mountland</u> 23d. LOCATION (city, town or county) (State) <u>Bald</u> | |
| 24. FUNERAL DIRECTOR <u>Old Skewany</u> 25a. REC'D BY REGISTRAR <u>AUG 21 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u> | | 25c. ADDRESS <u>6067 Hay Rd</u> | |

10770

CERTIFICATE OF DEATH

21672

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Baltimore County General Hospital</u> | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>3501 Olympia Avenue #15</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>William E. Stain</u> First Middle Last 4. DATE OF DEATH <u>August 12 1967</u> Month Day Year | | 5 SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> 11 BIRTHPLACE (County & State, or foreign country) <u>Lithuania</u> 12 CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> 16 SOCIAL SECURITY NO. <u>No</u> 17 INFORMANT <u>Mr. Harry Krongard, 3501 Olympia Avenue</u> Address | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Death Syndrome, probable CVA</u> (b) <u>@ optic neuritis</u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Not Known</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8-10</u> , 19 <u>67</u> , to <u>8-12</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>8-12</u> , 19 <u>67</u> , and that death occurred at <u>7:25a</u> M, from causes and on the date stated above | | | |
| 22a. SIGNATURE <u>Diadema B. Simon, MD.</u> 22c. PHYSICIAN'S NAME (Type) <u>Diadema B. Simon</u> | | 22b. DATE SIGNED <u>8-12-67</u> 22d. ADDRESS <u>Baltimore County General Hospital</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>8/14/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u> 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>AUG 17 1967</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | |
| 24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Peisterstown</u> | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME(15)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10771

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12176

| | | | | | |
|--|--|---|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | c. LENGTH OF STAY IN 1b Baltimore | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Florida b. COUNTY Miami Beach | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | d. STREET ADDRESS Miami Beach, Florida | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) ALFRED STERN | | 4 DATE OF DEATH August 22 19 67 | | 5 SEX Male | |
| 6 COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 AGE (In years lost birthday) 53 yrs | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12 CITIZEN OF WHAT COUNTRY? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16 SOCIAL SECURITY NO. | | 17 INFORMANT Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Russell S. Fisher, M.D. | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22. DATE SIGNED August 23, 1967 | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| Address (Street, city, town, or county) | | 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF 9-11-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY 10.9md. Med. School | | 23d. LOCATION (City or Town) Baltimore Md. | | 23e. LOCATION (County) Baltimore | |
| 23f. LOCATION (State) Md. | | 24 FUNERAL DIRECTOR ADDRESS | | 25a. REC'D BY REG STRAR DATE SEP 13 1967 | |
| 25b. REG STRAR'S SIGNATURE J. Charles Young | | | | | |

100

100

100

100

100 100 100 100 100

100

100 100 100

100 100 100 100 100

100

CERTIFICATE OF DEATH

10772

10772

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOUWSON</u> | | c. LENGTH OF STAY IN 1b <u>2 DAYS</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>G. L. EATER BALTIMORE MEDICAL CENTER</u> | | d. STREET ADDRESS <u>1815 Harford Rd.</u> | |
| 3 NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>(NHN)</u> Last <u>STIRZEL</u> | | 4. DATE OF DEATH Month <u>8</u> Day <u>22</u> Year <u>19 67</u> | |
| 5 SEX <u>F</u> | 6 COLOR OR RACE <u>W</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>12-1-1888</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NA</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (in years last birthday) <u>78</u> yrs. |
| 11 BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MARYLAND</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13 FATHER'S NAME <u>Adolph E. Frick</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna Gusner</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16 SOCIAL SECURITY NO. <u>215-24-2103</u> | |
| 17. INFORMANT <u>PT'S. HOSPITAL CHART</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CA metast.</u> DUE TO (b) <u>Adenocarcinoma of the stomach with metast.</u> DUE TO (c) <u>to colon - Subphrenic abscess</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8/20</u> , 19 <u>67</u> , to <u>8/22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>morning 8/22/1967</u> , and that death occurred at <u>11:22 AM</u> , from causes and on the date stated above | | | |
| 22a. SIGNATURE <u>Nasser Eftekhari</u> | | 22b. DATE SIGNED <u>8/22/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>NASSER EFTEKHARI M.D.</u> | | 22d. ADDRESS <u>6701 N. Charles St Balto MD. 21204</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>8-25-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u> | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u> |
| 24. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home, Inc</u> <u>6500 York Road Baltimore, Md. 21212</u> | | 25a. REC'D BY REGISTRAR DATE <u>AUG 28 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>Richard Judge</u> |

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10773

10773

CERTIFICATE OF DEATH

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown | | c. LENGTH OF STAY IN TB 57 years | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 103 Westminster Rd. | | d. STREET ADDRESS 103 Westminster Rd. | |
| 3. NAME OF DECEASED (Type or print) Leola May Stolpp | | 4. DATE OF DEATH Month August Day 22 Year 1967 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 17, 1889 |
| 9. AGE (In years last birthday) 77 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | 11. IF UNDER 24 HRS Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY --- | |
| 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William S. Worrell | | 14. MOTHER'S MAIDEN NAME Ida May Wink | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO 220-44-4885 | |
| 17. INFORMANT Mrs. Phyllis Fox | | Address Walnut Avenue, Owings Mills, Md. | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO L. V. & R. Hypertension DUE TO Decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | INTERVAL BETWEEN ONSET AND DEATH 10 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1-1-1967 to 8-22-1967 , that (I) (we) last saw the deceased alive on 8-21-1967 , and that death occurred at 10 AM , from causes on and the date stated above. | | | |
| 22a. SIGNATURE James G. Saffell M.D. | | 22b. DATE SIGNED 8-22-67 | |
| 22c. PHYSICIAN'S NAME (Type) James G. Saffell M.D. | | 22d. ADDRESS Reisterstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Aug. 24, 1967 | 23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | 23d. LOCATION (City or Town) (County) (State) Pikesville, Maryland. |
| 24. FUNERAL DIRECTOR H. J. Schhardt | | 25a. REC'D BY REGISTRAR Charles Judge | |
| ADDRESS Owings Mills, Md. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |
| DATE AUG 25 1967 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1'67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10774

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10774

| | | | |
|---|---|---|--|
| 1 PLACE OF DEATH a COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Edgemere | | c LENGTH OF STAY IN 1b 1 Year | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7331 Waldman Ave. 21219 | | e STREET ADDRESS 7331 Waldman Ave. 21219 | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Catherine M. Stritmater | | 4 DATE OF DEATH Month Day Year August 5 1967 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 11/25/81 |
| 9 AGE (In years last birthday) yrs 85 | | 10 UNDER 1 YEAR Months Days Hours Min 1967 | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (State or foreign country) Scotland | | 12 CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13 FATHER'S NAME Donald Munroe | | 14 MOTHER'S MAIDEN NAME Mary Taylor | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16 SOCIAL SECURITY NO 116-14-6679 | |
| 17 INFORMANT (Son) Donald J. Stritmater, 7331 Waldman Ave. | | 18 Edgemere, Md. 21219 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) A-S-C-V-Disease 4221 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Senility - (c) PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | INTERVAL BETWEEN ONSET AND DEATH - |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Melvin B. Davis M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6800 Morningside Rd. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Dundalk, DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Md. 21222 Address (Street city town, or county) | |
| 22. DATE SIGNED 8/7/67 | | | |
| 23a BURIAL CREMATION, REMOVAL (Specify) Burial | 23b DATE THEREOF 8/9/67 | 23c NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | 23d LOCATION (City or town) (County) (State) Baltimore, Maryland |
| 24 FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md. | | 25a REC'D BY REGISTRAR DATE AUG 9 1967 | 25b REGISTRAR'S SIGNATURE J. Charles Judge |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 (Page 5 may be retained for your files).

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|-----------------------------------|--|---|
| 1 PLACE OF DEATH a COUNTY <u>Baltimore</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Westwood, Md.</u> | | c LENGTH OF STAY IN INSTITUTION <u>22yr 4 months</u> | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Spring Grove Hospital</u> | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) <u>Michael Jerome Summers</u> | | 4 DATE OF DEATH Month <u>8</u> / Day <u>31</u> / Year <u>1967</u> | |
| 5 SEX <u>M</u> | 6 COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>4/12/03</u> |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Work</u> | | 10b KIND OF BUSINESS OR INDUSTRY <u>FARMER</u> | |
| 11 BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John K. Summers</u> | | 14 MOTHER'S MAIDEN NAME <u>Agnes Regina Hill</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16 SOCIAL SECURITY NO <u>None Known</u> | |
| 17 INFORMANT <u>Spring Grove Hospital</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. <u>4221</u> IMMEDIATE CAUSE (a) <u>Cardio-vascular Disease</u> DUE TO (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenia (Patient at Spring Grove Hospital)</u> | | | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of form 10) | |
| 20c TIME OF INJURY Month Day Year Hour <u>0</u> m <u>0</u> p.m. 19 <u>67</u> | | 20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>J. N. Frederick MD</u> | | 22. DATE SIGNED <u>8/31/67</u> | |
| EXAMINER'S NAME (Type) <u>J. N. Frederick MD</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>1311 Francis Ave. Balto. MD. 21227</u> | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b DATE THEREOF <u>9-4-67</u> | 23c NAME OF CEMETERY OR CREMATORY <u>ST PETERS Cem.</u> | 23d LOCATION (City or Town) (County) (State) <u>WALDORF CHARLES, MD.</u> |
| 24. FUNERAL DIRECTOR <u>The HUNTT FUNERAL HOME, WALDORF, MD.</u> | | 25a REC'D BY REGISTRAR <u>SEP 6 1967</u> | |
| ADDRESS | | 25b REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|-------------------------------|---|--|---|----------------------------------|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 10776 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN 1b 3 1/2 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown d. STREET ADDRESS R.D. #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) First Carol Middle Sue Last SWOPE | | | 4. DATE OF DEATH Month 8 Day 2 Year 19 67 | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11/21/62 | | 9. AGE (in years last birthday) 4 yrs. IF UNDER 1 YEAR: Months 4 Days 4 Hours 4 Min. 4 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME LaVerne Swope | | | | | 14. MOTHER'S MAIDEN NAME FANNON, Bertha F | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT Rosewood Records, Owings Mills, Md. Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital malformation of the brain DUE TO (b) Bronchopneumonia, bilateral DUE TO (c) Generalized convulsions | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH since birth 6-days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/23 , 19 63 , to 8/21 , 19 67 , that (I) (we) last saw the deceased alive on 8/21 , 19 67 , and that death occurred at 8:45 PM , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Hsu Ku-Shin | | | | | 22b. DATE SIGNED | | | 22c. PHYSICIAN'S NAME (Type) Hsu Ku-Shin, M.D. | |
| 22d. ADDRESS Rosewood Lane, Owings Mills, Md. | | | | | 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF 8/5/67 | | 23c. NAME OF CEMETERY OR CREMATORY Meadow Branch Cemetery | | 23d. LOCATION (City, town or county) (State) | | |
| 24. FUNERAL DIRECTOR J.S. Myers Jr. Westminster, Md. | | | | | 25a. REC'D BY REGISTRAR AUG 7 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |



CERTIFICATE OF DEATH

10777

10777

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|---|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY -- | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN 1b 18 Days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Balto med Center | | e. STREET ADDRESS 604 South Linwood Ave | |
| 3 NAME OF DECEASED (Type or print) Victoria Eva SzumLanski | | 4 DATE OF DEATH Month August Day 22 Year 1967 | |
| 5 SEX Fe | 6 COLOR OR RACE Cauc | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8 DATE OF BIRTH 12-24-03 |
| 9 AGE (In years lost birthday) 63 yrs | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (County & State, or foreign country) BALTO-MD. |
| 12 CITIZEN OF WHAT COUNTRY? USA | 13. FATHER'S NAME Robert Lisek | 14. MOTHER'S MAIDEN NAME Magdaline Koscielniak | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No | 16 SOCIAL SECURITY NO. 212-16-8133 | 17. INFORMANT (Husband) John J. Szumlanski Sr. Address Balto. Md. 604 S. Linwood Ave. | |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory failure DUE TO (b) CA of breast with long metastases DUE TO (c) CA of breast with long metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 8.4 , 19 67 , to 8.22 , 19 67 , that (I) (we) last saw the deceased alive on 8.22 19 67 , and that death occurred at 5:45 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Rahim M. Bassiri | | 22b. DATE SIGNED 8/22/67 | |
| 22c. PHYSICIAN'S NAME (Type) Rahim M. Bassiri | | 22d. ADDRESS Greater Balto. Med. Center, Towson, Md. | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/26/67 | 23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland |
| 24. FUNERAL DIRECTOR John J. Duda, 2329 Hudson St. Balto. Md. | | 25a. REC'D BY REGISTRAR DATE AUG 25 1967 | 25b. REGISTRAR'S SIGNATURE Charles Judge |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10778

CERTIFICATE OF DEATH

10778

| | | | |
|--|---|---|--|
| 1 PLACE OF DEATH a COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b. COUNTY HARFORD | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson | | c LENGTH OF STAY IN 1b 43 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First WILMER Middle C. Last TEAT | | 4 DATE OF DEATH Month AUG. Day 24 Year 1967 | |
| 5 SEX M | 6 COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 2-28-03 |
| 9 AGE (In years last birthday) 64 yrs | | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAB DRIVER | | 10b KIND OF BUSINESS OR INDUSTRY Taxi Cab. | |
| 11 BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12 CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME SAVILLER TEAT | | 14. MOTHER'S MAIDEN NAME LUCINDA KNOTTS | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16 SOCIAL SECURITY NO 220-05-8096 | |
| 17 INFIRMANT Records, Mt. Wilson State Hospital | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia T.B., FAR ADVANCED, ACTIVE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19 WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour "a.m. 19 p.m. | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from 7-13- , 1967, to 8-24- , 1967, that (I) (we) last saw the deceased alive on 8-24 1967, and that death occurred at 2:45 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE W. Newcomer M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Supt. | | 22d. ADDRESS Mt. Wilson, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Aug. 27, 1967 | 23c. NAME OF CEMETERY OR CREMATORY Crumpton Cemetery. | 23d. LOCATION (City or Town) (County) (State) Crumpton, Q.A. Md. |
| 24. FUNERAL DIRECTOR Edward Tellows | | 25a. REC'D BY REGISTRAR DAUG 28 1967 | |
| ADDRESS Millington, Md. | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10779

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10779

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> | | c. LENGTH OF STAY IN 1b <u>Dundalk</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>218 Baltimore Ave.</u> | | d. STREET ADDRESS <u>218 Baltimore Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Oskar</u> Middle <u>Terna</u> Last <u>Terna</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1967</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-16-1889</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) <u>78</u> yrs. |
| 11. BIRTHPLACE (State or foreign country) <u>Estonia</u> | | 12. COUNTRY OF WHAT COUNTRY? <u>Estonia</u> | |
| 13. FATHER'S NAME <u>Not known</u> | | 14. MOTHER'S MAIDEN NAME <u>Not known</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>101260904</u> | |
| 17. INFORMANT <u>Kaljo Popp</u> | | Address <u>226 S. Oldham Street</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>A-s-c-v-Disease</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>—</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>M. B. Davis</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>M. B. Davis M.D. 6800 Minn.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u> | | 23b. DATE THEREOF <u>8-24-67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematory</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u> | | 25a. RECEIVED BY REGISTRAR DATE <u>AUG 23 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles J. J.</u> | |

22. DATE SIGNED
8/23/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO JUNEAU DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. LENGTH OF STAY IN 1b 12 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS 3721 E. PRATT STREET | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle A. Last THAWLEY | | 4. DATE OF DEATH Month AUGUST Day 17 Year 19 67 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 18, 1912 |
| 9. AGE (In years last birthday) 55 yrs | | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DIE SETTER | | 10b. KIND OF BUSINESS OR INDUSTRY CAN COMPANY | |
| 11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME SAMUEL THAWLEY | | 14. MOTHER'S MAIDEN NAME ELIZABETH MARY FREEDA | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II | | 16. SOCIAL SECURITY NO 215 01 83 54 | |
| 17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA DUE TO (b) CIRRHOSIS OF LIVER DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 4 DAYS UNKNOWN | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PEPTIC ULCER. HYPERTENSIVE HEART DISEASE | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/5/67 , 19__, to 8/17/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/17/67 , 19__, and that death occurred at 11:00A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Ahmed Kutty | | 22b. DATE SIGNED 8/17/67 | |
| 22c. PHYSICIAN'S NAME (Type) AHMED C. K. KUTTY, M. D. | | 22d. ADDRESS VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 8/21/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR F. Fisher | | 25a. RECEIVED BY REGISTRAR AUG 21 1967 | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | 25c. DATE 1930 EASTERN AVENUE, BALTIMORE, MD. | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item #2c & d Fill

CERTIFICATE OF DEATH

10781

10781

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 21220</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House In the Pines (Nursing Home)</u> | | d. STREET ADDRESS <u>4 Cromarty Rd. 1611 Frustrating Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>V.</u> Last <u>Thomas</u> | | 4. DATE OF DEATH Month <u>8</u> Day <u>22</u> Year <u>1967</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. B. DATE OF BIRTH <u>9-25-1883</u> |
| 9. AGE (In years last birthday) <u>83</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>BALTO., MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Late - Albert C. Thomas</u> | | 14. MOTHER'S MAIDEN NAME <u>Late - Sarah V. -----</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO <u>-----</u> | |
| 17. INFORMANT <u>Mrs. Harry Altvater</u> | | Address <u>4 Cromarty Rd. - 21228</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASCVD</u> DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>6-9</u> , 19 <u>67</u> , to <u>present</u> , 19 <u> </u> , that I last saw the deceased alive on <u>7-29</u> , 19 <u>67</u> , and that death occurred at <u>4:AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>L. Kemper Owens</u> M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED <u>6 E. Road St., Baltimore, Md. 8-2267</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>8/24/67</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke F. D. - 4101 Edmondson Av.</u> | | 24a. REC'D BY REGISTRAR DATE <u>AUG 23 1967</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10782

10782

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | | c. LENGTH OF STAY IN 1b <u>45</u> DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balt. Med. Center</u> | | d. STREET ADDRESS <u>4602 Furley Ave. Baltimore, Md.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Thomas Helen Lorena</u> First Middle Last | | 4. DATE OF DEATH <u>8-22-1967</u> Month Day Year | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Cau.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-11-95</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | |
| 11. BIRTHPLACE (County & State or foreign country) <u>Balt.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Louis Lentgraf (Dec.)</u> | | 14. MOTHER'S MAIDEN NAME <u>KUHL</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NA.</u> | | 16. SOCIAL SECURITY NO. <u>NA.</u> | |
| 17. INFORMANT <u>Admission Sheet</u> Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Conjunctive Heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bilateral pleural effusion</u> (c) <u>Ca of breast to metastasis to lung?</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (the hospital) attended the deceased from <u>8-18</u> , 19 <u>67</u> , to <u>8-22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-22</u> , 19 <u>67</u> and that death occurred at <u>2:50 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Jose M. de Leon</u> M.D. | | 22b. DATE SIGNED <u>8-22-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>JOSE M. DE LEON, M.D.</u> | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>8-26-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore City Md.</u> |
| 24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Road</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | 25b. REGISTRAR'S SIGNATURE |
| DATE <u>AUG 28 1967</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10783

CERTIFICATE OF DEATH

10783

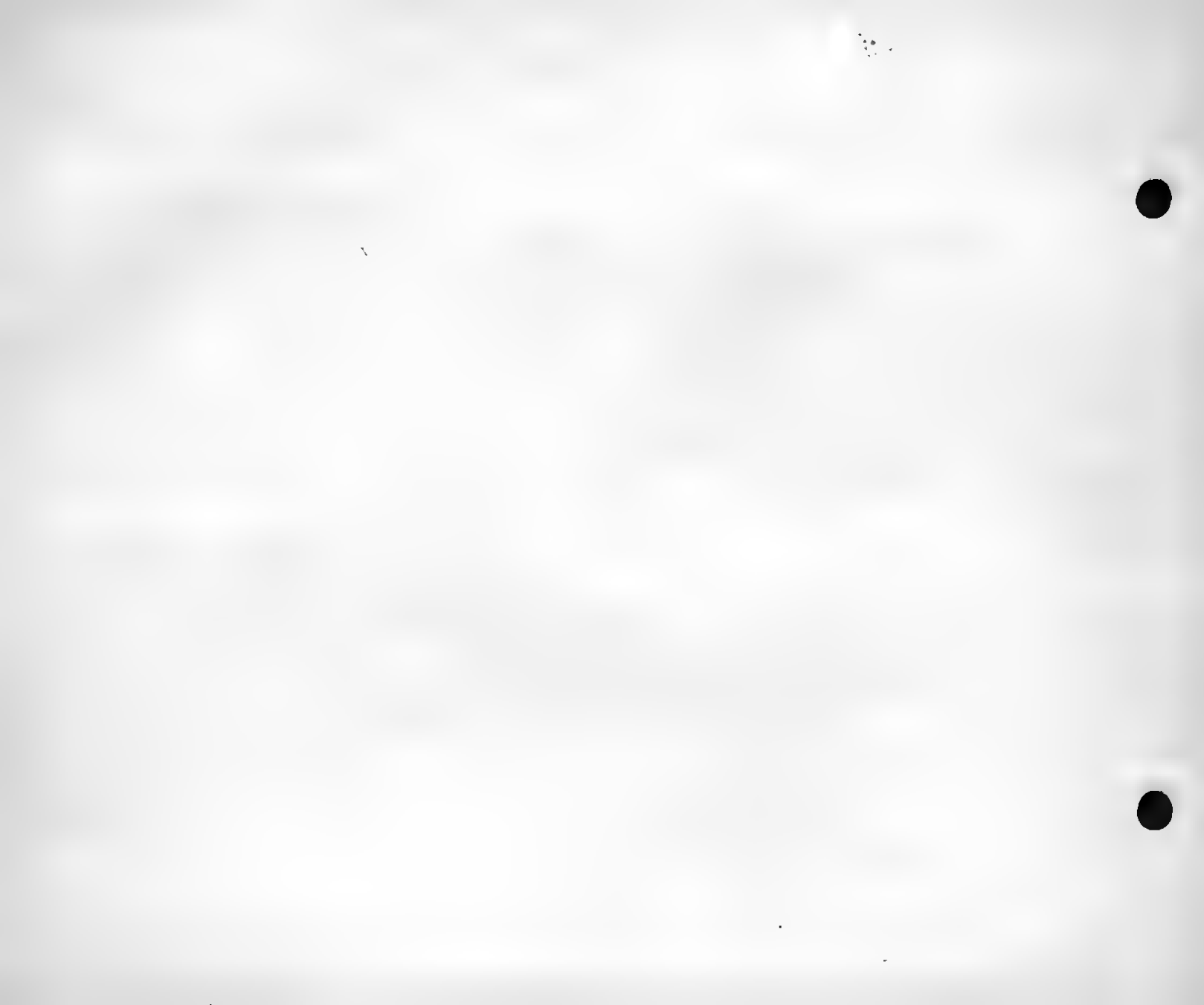
| | | | | | | | |
|---|--|--|-------------------------|--|--|--|--|
| 1 PLACE OF DEATH a COUNTY Baltimore MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor Nursing Home | | | | d. STREET ADDRESS 909 Beaumont Ave. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Helen F. Thompson | | | | 4 DATE OF DEATH Month Day Year August 29 19 67 | | | |
| 5 SEX F | | 6 COLOR OR RACE W | | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH 5/25/1888 | |
| 9 AGE (In years last birthday) 79 yrs | | 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b KIND OF BUSINESS OR INDUSTRY Own Home | | 11 BIRTHPLACE (County & State, or foreign country) New Jersey | |
| 12 CITIZEN OF WHAT COUNTRY? U. S. A. | | | | 13 FATHER'S NAME Frames | | | |
| 14 MOTHER'S MAIDEN NAME Unknown | | | | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | |
| 16 SOCIAL SECURITY NO. 212-03-3441R | | | | 17. INFORMANT Address Stanton, Conn R. B. Thompson, 315 Emory Drive, | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH 10 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) DUE TO | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diverticulosis | | | | | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) | | 20f (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June , 19 62 , to Aug. 29, 1967 , that (I) (we) last saw the deceased alive on Aug. 27, 1967 , and that death occurred at 7:42 M. from causes and on the date stated above. | | | | | | | |
| 22a SIGNATURE Lloyd E. Saylor M.D. | | | | 22b DATE SIGNED Aug. 29, 1967 | | 22c PHYSICIAN'S NAME (Type) Dr. Lloyd E. Saylor | |
| 22d ADDRESS 3902 Greenmount Ave. | | | | 22e MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE THEREOF 8/31/67 | | 23c NAME OF CEMETERY OR CREMATORY Loudon Park | | 23d LOCATION (City or Town) (County) (State) Baltimore, Md. | |
| 24 FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | | 25a REC'D BY REGISTRAR DATE SEP 1 1967 | | 25b REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| <div style="display: flex; justify-content: space-between;"> <div>10784</div> <div> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 </div> <div>10784</div> </div> | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | | | c. LENGTH OF STAY IN 1b days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GRATER BALT MEDICAL CENTER | | | | | | d. STREET ADDRESS 25 Haddington Road | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Joseph Middle ARNEL Last THRIFT | | | | | | 4. DATE OF DEATH Month AUG Day 21 Year 1967 | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3-2-1915 | | 9. AGE (In years lost birthday) 52 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operation | | | | 10b. KIND OF BUSINESS OR INDUSTRY HUMBLE OIL CO. | | 11. BIRTHPLACE (County & State, or foreign country) TUCKER HILL, VA. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME IRVING THRIFT | | | | | | 14. MOTHER'S MAIDEN NAME VIOLA SPILMAN | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ? (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO 225-09-8488 | | 17. INFORMANT Address CORNELIA CARTER THRIFT | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO (b) Hodgkin's disease with Radiation therapy DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/16 , 19 67 , to 8/ , 19 67 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 8 M, from causes and on the date stated above | | | | | | | | | | | |
| 22a. SIGNATURE Derek A. Bruce | | | | | | MD <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 8/21/67 | | | |
| 22c. PHYSICIAN'S NAME (Type) DEREK A. BRUCE | | | | | | 22d. ADDRESS G.B.M.C. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF Aug. 23, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Westhampton Memorial Park | | | | 23d. LOCATION (City or Town) (County) (State) Richmond, Virginia | | | |
| 24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road | | | | | | 25a. REC'D BY REGISTRAR AUG 24 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



10785

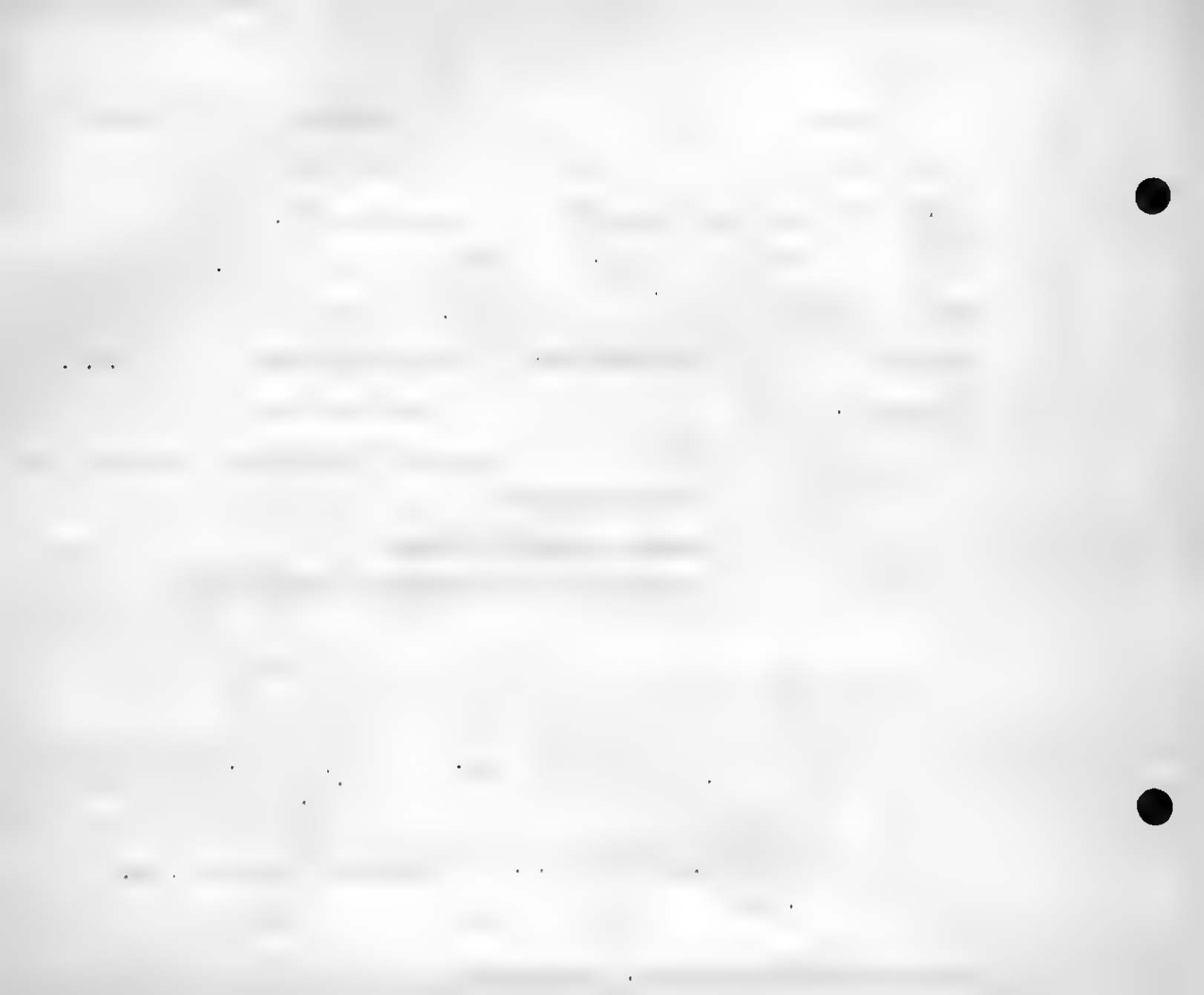
CERTIFICATE OF DEATH

10785

| | | | |
|--|---|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 3 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital | | e. STREET ADDRESS 1911 Walnut Ave. | |
| 3 NAME OF DECEASED (Type or print) HARRISON FRANCIS TOLLEY | | 4. DATE OF DEATH Month Aug. Day 11 Year 19 67 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Jan. 28, 1908 59 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Baltimore Sewers | 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland |
| 13. FATHER'S NAME Harrison F. Tolley | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 11 | | 16. SOCIAL SECURITY NO 438 03 50 57 | |
| 17. INFORMANT Catherine Bigney | | Address Clinical Recds VA Hospital, Fort Howard, Md. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO (b) CEREBRAL VASCULAR ACCIDENT DUE TO (c) THROMBOSIS OF THE LEFT MIDDLE CEREBRAL ARTERY | | | INTERVAL BETWEEN ONSET AND DEATH 3 days 1 week |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____ | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug. 8 , 19 67 , to Aug. 11 , 19 67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Aug. 11 , 19 67 , and that death occurred at 7:45M , from causes and on the date stated above. | | | |
| 22a SIGNATURE <i>Deogracias V. Faustino, M.D.</i> | | 22b. DATE SIGNED 8/12/67 | |
| 22c. PHYSICIAN'S NAME (Type) DEOGRACIAS V. FAUSTINO, M.D. | | 22d. ADDRESS VA Hospital, Fort Howard, Md. | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 8/15/67 | 23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery | 23d. LOCATION (City or Town) (County) (State) Baltimore Maryland |
| 24. FUNERAL DIRECTOR DUDAS FUNERAL HOME, WISE AVE. BALTIMORE, MD. | | 25a REC'D BY REGISTRAR DATE AUG 14 1967 | |
| | | 25b REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 5, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



10786

CERTIFICATE OF DEATH

10786

| | | | |
|---|---|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>Balto.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u> c. LENGTH OF STAY IN 1b <u>Baltimore</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto County General Hospt.</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2617 Poplar Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) <u>Reba</u> First Middle Last <u>(NMI) TOPAZ</u> | | 4 DATE OF DEATH Month <u>8</u> Day <u>1</u> Year <u>1967</u> | |
| 5 SEX <u>Female</u> | 6 COLOR OR RACE <u>White</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>Aug 20, 1896</u> 9. AGE (In years last birthday) <u>70</u> yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | 11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Nathan Chernoff</u> | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO <u>215-48-5424</u> | 17. INFORMANT <u>Mrs. Norma Moritz, 2617 Poplar Drive</u> Address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7-20</u> , 19 <u>67</u> , to <u>8-1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-1</u> , 19 <u>67</u> , and that death occurred at <u>9:20 PM</u> , from causes and on the date stated above | | | |
| 22a. SIGNATURE <u>M. Khader</u> | | 22b. DATE SIGNED <u>8/1/67</u> M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) <u>M. Khader</u> | | 22d. ADDRESS <u>Baltimore County General Hospital</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>8/3/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Chizuk Amuno (Arlington)</u> | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u> | | 25a. REC'D BY REGISTRAR <u>AUG 7 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

10787

10787

| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson | | c. LENGTH OF STAY IN lb 3 mos. 25 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Wilson State Hospital | | d. STREET ADDRESS RD 1, Box 17-A | |
| 3. NAME OF DECEASED (Type or print) CHARLES WILLIAM TOWNLEY | | 4. DATE OF DEATH Month AUGUST Day 28 Year 1967 | |
| 5. SEX M. | 6. COLOR OR RACE G | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 8-7-07 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TANITOR | | 10b. KIND OF BUSINESS OR INDUSTRY Government | 9. AGE (in years) 60 (last birthday) 38/1 yes |
| 11 BIRTHPLACE (County & State, or foreign country) Virginia | | 12 CITIZEN OF WHAT COUNTRY? USA. | |
| 13. FATHER'S NAME ANDREW TOWNLEY | | 14. MOTHER'S MAIDEN NAME MARY V. BROOKS. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. 218-07-1370 | |
| 17. INFORMANT Records, Mt. Wilson State Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary embolism DUE TO 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) post operative status of left upper lobectomy due to cancer. DUE TO Hydropneumothorax. (c) | | INTERVAL BETWEEN ONSET AND DEATH 22 days | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 5-5-1967 to 8-28-1967 , that (I) (we) last saw the deceased alive on 8-28-1967 , and that death occurred at 6:25 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE W. Newcomer | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Supt. | | 22d. ADDRESS Mt. Wilson, Maryland | |
| 23a. BURIAL CREMATION, (Specify) Burial | 23b. DATE THEREOF 9/2/1967 | 23c. NAME OF CEMETERY OR CREMATORY Jones Mem. Cemetery | 23d. LOCATION (City or Town) (County) (State) Port Deposit, Md Rural |
| 24. FUNERAL DIRECTOR Sec 9 Baltimore and Son, Pynnsle Md | | 25a. REC'D BY REGISTRAR SEP 6 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE James Jones | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10788

CERTIFICATE OF DEATH

10788

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Hospital</u> | | d. STREET ADDRESS <u>Thornton Road</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Talbott Tracey</u> | | 4. DATE OF DEATH Month Day Year <u>August 4, 1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>August 17, 1910</u> |
| 9. AGE (In years last birthday) yrs <u>56</u> | | 10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Thomas Edward Freeland</u> | | 14. MOTHER'S MAIDEN NAME <u>Hattie Rogers</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>219-28-9404</u> | |
| 17. INFORMANT <u>Family records</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis - original</u> DUE TO (b) <u>resuscitation</u> DUE TO (c) <u>no cause</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 28, 1967</u> , to <u>Aug 4, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 4, 1967</u> , and that death occurred at <u>8 P.M.</u> from causes and on the date stated above | | | |
| 22a. SIGNATURE <u>James G. Saffell</u> | | 22b. DATE SIGNED <u>8-2-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>James G. Saffell</u> | | 22d. ADDRESS <u>Reisterstown, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF <u>Aug. 8, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Jessop's Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Cockeysville, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u> | | 25a. REC'D BY REGISTRAR DATE <u>AUG 8 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|--|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| 10789 | | | |
| CERTIFICATE OF DEATH | | | |
| 10789 | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Brooklandville</u> | | c. LENGTH OF STAY IN 1b <u>Rural Brooklandville, Md.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Valley Road, Brooklandville, Md.</u> | | d. STREET ADDRESS <u>Valley Road</u> | |
| 3. NAME OF DECEASED (Type or print) <u>David Milton Trager, Jr.</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>1967</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7/14/89</u> |
| 9. AGE (In years past birthday) <u>78</u> yrs | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u> | |
| 11. BIRTHPLACE (County & State or foreign country) <u>Baltimore Co., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George Trager</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Menchen</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>None</u> | | 16. SOCIAL SECURITY NO <u>212-07-3147</u> | |
| 17. INFORMANT <u>Mr. David M. Trager, Jr.</u> | | Address <u>Woodlawn, Md.</u> <u>2023 J. Woodlawn Drive</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u> </u> (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | 20f. (City or town) (County) (State) <u> </u> |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 22, 1967</u> , to <u>Aug. 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 22, 1967</u> , and that death occurred at <u>8:30 a.m.</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>William A. Pillsbury</u> | | 22b. DATE SIGNED <u>8-8-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>William A. PILLSBURY</u> | | 22d. ADDRESS <u>TIMONIUM, MD.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Aug. 10, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Pikesville 8, Md.</u> |
| 24. FUNERAL DIRECTOR <u>Frank H. Newell</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| ADDRESS <u>Pikesville 8, Md.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE <u>AUG 11 1967</u> | | | |



10790

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10790

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|-------------------------------------|---|--|
| 1 PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Balto. Md. #8</u> | | c. LENGTH OF STAY IN 1b <u>3 da.</u> | |
| c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Balto. 21288</u> | | d. STREET ADDRESS <u>3306 Janelle Dr</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3306 Janelle Drive</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) <u>DORRIS VIRGINIA TRAVERS</u> | | 4. DATE OF DEATH <u>Aug 21 1967</u> | |
| 5 SEX <u>Female</u> | 6 COLOR OR RACE <u>White</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>9-7-14</u> |
| 9 AGE (In years, lost birthday) <u>52 yrs</u> | | 10 IF UNDER 1 YEAR Months Days | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u> | | 10b KIND OF BUSINESS OR INDUSTRY <u>Private Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13 FATHER'S NAME <u>Wilbert H. Travers Sr.</u> | | 14 MOTHER'S M maiden name <u>Williamina Morgan?</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16 SOCIAL SECURITY NO <u>22-30-0977</u> | |
| 17 INFORMANT <u>Wilbert H. Travers Jr.</u> | | Address <u>7 Kimbark Ave. - Baltimore</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None.</u> | | | |
| 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> <u>None</u> | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <u>None.</u> | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>None</u> | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <u>None.</u> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None.</u> | | 20f (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>D.D. Catles</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>D.D. CATLES</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | Address (Street, city, town, or county) | |
| 22. DATE SIGNED <u>8/21/67</u> | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b DATE THEREOF <u>Aug 24 1967</u> | 23c NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Pk</u> | 23d LOCATION (City or Town) (County) (State) <u>Glen Burnie Md</u> |
| 24. FUNERAL DIRECTOR <u>Engine B. Plamere</u> | | 25a. REC'D BY REGISTRAR <u>Aug 23 1967</u> | |
| ADDRESS <u>Singleton Funeral Home Glen Burnie Md</u> | | 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10791

CERTIFICATE OF DEATH

10791

| | | | |
|--|-----------------------------------|--|--|
| 1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if instit on Res dence before admss on) a. STATE MARYLAND b. COUNTY BALTIMORE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ICWSON | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FULLERTON | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. JOSEPH HOSP DOA. | | d. STREET ADDRESS 7855 BELAIR ROAD | |
| 3. NAME OF DECEASED (Type or print) THEODORE First Middle Last | | 4. DATE OF DEATH AUGUST 30 1967 Month Day Year | |
| 5 SEX MALE | 6. COLOR OR RACE CAUCASIAN | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JUNE 3 1919 9. AGE (In years lost birthday) 48 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN | | 10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION REPAIR | |
| 11 BIRTHPLACE (County & State or foreign country) BALTIMORE | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME THEODORE TRUSS | | 14. MOTHER'S MAIDEN NAME HELEN L. LENTOWSKI | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16 SOCIAL SECURITY NO. 219-01-7650 | |
| 17. INFORMANT HELEN TRUSS | | Address 7855 BELAIR RD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Artery Disease 4. 1 DUE TO Hypertensive arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART-I (a) Extensive myocardial infarction with failure | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 1B) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 25 , 19 66 to Aug 28 , 19 67 , that (I) (we) last saw the deceased alive on Aug 28 , 19 67 and that death occurred at 10:30 PM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Frank T. Kasik Jr. MD | | 22b. DATE SIGNED 8/31/67 | |
| 22c. PHYSICIAN'S NAME (Type) FRANK T. KASIK JR. MD. | | 22d. ADDRESS 9005 HARFORD ROAD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF SEPT 2, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL | | 23d. LOCATION (City or Town) (County) (State) BALTO. CO. MD | |
| 24. FUNERAL DIRECTOR DIPPEL BROTHERS INC | | 25a. REC'D BY REGISTRAR SEP 5 1967 | |
| ADDRESS 715 BELAIR RD. 21206 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10792

CERTIFICATE OF DEATH

10792

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTER | |
| c. LENGTH OF STAY IN 1b 3 DAYS | | d. STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) JOHN W. TULL | | 4. DATE OF DEATH Month AUGUST Day 10 Year 1967 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH OCTOBER 9, 1924 |
| 9. AGE (In years lost birthday) yrs 42 | | 10. IF UNDER 1 YEAR Months 10 Days 19 Hours 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN | | 10b. KIND OF BUSINESS OR INDUSTRY FISHING | |
| 11. BIRTHPLACE (County & State or foreign country) CHESTER, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME GEORGE S. TULL | | 14. MOTHER'S MAIDEN NAME ANNA M. THOMPSON | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II | | 16. SOCIAL SECURITY NO. 215 20 04 95 | |
| 17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF THE LARYNX DUE TO (b) UNKNOWN DUE TO (c) UNKNOWN | | INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FEMORAL ARTERY OCCLUSION OR EMBOLISM | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/7/67 , 19__ to 8/10/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/10/67 , 19__, and that death occurred at 1:40AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>George C. McElpatrick, M.D.</i> | | 22b. DATE SIGNED 8/10/67 | |
| 22c. PHYSICIAN'S NAME (Type) GEORGE C. MC ELPATRICK, M. D. | | 22d. ADDRESS VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF Aug. 13 | 23c. NAME OF CEMETERY OR CREMATORY STEVENSVILLE CEMETERY | 23d. LOCATION (City or Town) (County) (State) STEVENSVILLE, MARYLAND |
| 24. FUNERAL DIRECTOR <i>Edgar Lane</i> | | 25a. REC'D BY REGISTRAR AUG 15 1967 | |
| 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10793

10793

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | c. LENGTH OF STAY IN life Life | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St Joseph Hospital | | d. STREET ADDRESS 426 E. Lake Ave. | |
| 3. NAME OF DECEASED (Type or print) Myron Griffin Tull | | 4. DATE OF DEATH Month 8 Day 18 Year 19 67 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7/25/1889 |
| 9. AGE (In years last birthday) 78 yrs | | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Thomas Tull | | 14. MOTHER'S MAIDEN NAME Helen Robinson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I | | 16. SOCIAL SECURITY NO. 220-44-4113 T | |
| 17. INFORMANT Mrs. Ella Nora Baer Tull | | Address Same | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4:01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED Where <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 8/14 , 19 67 to 8/18 , 19 67 , that (I) (we) last saw the deceased alive on 8/18 , 19 67 , and that death occurred at 9:03 p.m. from causes and on the date stated above | | | |
| 22a. SIGNATURE <i>[Signature]</i> M.D. | | 22b. DATE SIGNED 8/18/67 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Ismael Jamora M.D. | | 22d. ADDRESS St. Joseph Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8-21-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Slate Ridge | | 23d. LOCATION (City or Town) (County) (State) Delta, Penna. | |
| 24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. | | 25a. REC'D BY REGISTRAR DATE AUG 21 1967 | |
| 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10794

CERTIFICATE OF DEATH

10794

| | | | |
|---|---------------------------|--|-----------------------------------|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Harford | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c LENGTH OF STAY IN TB 2yr11mth6dys | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | e STREET ADDRESS 300 St. John St. | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Ada KATHERINE Turner | | 4 DATE OF DEATH Month Day Year August 29 19 67 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Sept. 27, 1913 |
| 9 AGE (In years last birthday) 53 yrs | | 10 IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b KIND OF BUSINESS OR INDUSTRY SAME | |
| 11 BIRTHPLACE (County & State, or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? U. S. | |
| 13 FATHER'S NAME William Fox | | 14 MOTHER'S MAIDEN NAME Carrie | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) UNK UNK | | 16 SOCIAL SECURITY NO UNK | |
| 17 INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Arteriosclerotic heart disease DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Cirrhosis of liver, mild - chronic alcoholism | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that (this hospital) attended the deceased from Sept. 23, 1964 to Aug. 29, 1967, that (we) saw the deceased alive on Aug. 29, 1967, and that death occurred at a M. from causes and on the date stated above. | | | |
| 22a SIGNATURE Stella Wachslar | | 22b DATE SIGNED 8-29-67 | |
| 22c PHYSICIAN'S NAME (Type) Stella Wachslar, M.D. | | 22d ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE THEREOF 8/31/1967 | |
| 23c NAME OF CEMETERY OR CREMATORY Angel Hill Cemetery | | 23d LOCATION (City or town) (County) (State) Havre de Grace Harford Md | |
| 24 FUNERAL DIRECTOR Cunningham & Son | | 25a REC'D BY REGISTRAR SEP 6 1967 | |
| 25b REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10795

10795

| | | | | | |
|---|--|--|--|---|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 2yrl0mthl1dys | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea, Maryland | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | | d. STREET ADDRESS 3819 Glenarm Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First John Middle Aven Last Tysor | | | 4. DATE OF DEATH Month August Day 20 Year 19 67 | | |
| 5 SEX male | 6. COLOR OR RACE white | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 9, 1896 | 9 AGE (In years lost birthday) 71 yrs | IF UNDER 1 YEAR Months 1 Days 19 Hours 67 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man | | 10b. KIND OF BUSINESS OR INDUSTRY Apt. Building | | 11. BIRTHPLACE (County & State, or foreign country) North Carolina | |
| 13. FATHER'S NAME Charles Tysor | | | 14. MOTHER'S MAIDEN NAME Minnie Morelen | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) C 3 061 753 Navy W.W.I | | 16. SOCIAL SECURITY NO. 217-20-1419 | | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, bilateral, organism unknown DUE TO (b) Bronchiectasis, chronic DUE TO (c) 3 years. | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 wks. |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | |
| 21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 9 , 19 64 to Aug. 20 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Aug. 20 , 19 67 , and that death occurred at 10:55 M, from causes and on the date stated above | | | | | |
| 22a. SIGNATURE <i>Anthony J. Young, M.D.</i> | | | 22b. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228 | | 22c. DATE SIGNED 8-21-67 |
| 22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/23/67 | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk. | 23d. LOCATION (City or Town) (County) (State) Anne Arundle Co., Md. | | |
| 24. FUNERAL DIRECTOR <i>James E. Bruzdinski</i> | | | 25a. REC'D BY REGISTRAR AUG 23 1967 | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

State Department of Health

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10796

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10796

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if not in residence before admission) a. STATE Maryland b. COUNTY f | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown | | | | c. LENGTH OF STAY IN TB | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore County General Hospital | | | | e. STREET ADDRESS 8033 Woodgate Court | | | |
| 3 NAME OF DECEASED (Type or print) First ALAN Middle R. Last UMIN | | | | 4 DATE OF DEATH Month August Day 13 Year 19 67 | | | |
| 5 SEX Male | | 6 CO. OR OR RACE White | | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH July 1, 1950 | |
| 9 AGE (In years last birthday) yrs 17 | | IF UNDER 1 YEAR Months 17 Days 17 Hours 17 Min 17 | | 11 BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | | | 10b. KIND OF BUSINESS OR INDUSTRY School | | | |
| 13 FATHER'S NAME Joseph Louis Umin | | | | 14 MOTHER'S MAIDEN NAME Ruth Oninberg | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | | 16 SOCIAL SECURITY NO | | 17 INFORMANT Mr. Joseph L. Umin, 8033 Woodgate Court | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hanging DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Hung self | | | |
| 20c. TIME OF INJURY Month, Day, Year 10 8/13 19 67 | | | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) In-Laws Home | |
| 20f. (City or town) (County) (State) Baltimore, Md. | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Werner U. Spitz, M.D. | | | | 22. DATE SIGNED 8/14/67 | | | |
| EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | |
| 23b. DATE THEREOF 8/15/67 | | | | 23c. NAME OF CEMETERY OR CREMATORY Mikro Kodesh Beth Israel | | | |
| 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | | | | 23e. REC'D BY REGISTRAR Rd. 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |
| 24. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reist., | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10797

CERTIFICATE OF DEATH

10797

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| c. LENGTH OF STAY IN 1b | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | | | d. STREET ADDRESS 423 Hutchins Ave. #21212 | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3 NAME OF DECEASED (Type or print) Harold Seymour Vassar | | | | 4. DATE OF DEATH Month August Day 29 Year 1967 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH September 4, 1912 | |
| 9. AGE (In years last birthday) 54 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bugle Laundry | | 11. BIRTHPLACE (County & State, or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME UNK. | | | | 14. MOTHER'S MAIDEN NAME ROSE VASSAR | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 225-03-0366 | | | | 17. INFORMANT Mrs. Mildred Vassar | | | |
| 16. SOCIAL SECURITY NO 423 Hutchins Ave. | | | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Diabetic Acidosis DUE TO (c) Pneumonia (d) Urinary tract infection | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from August 29, 1967 , to August 29, 1967 , that (I) (we) last saw the deceased alive on August 29, 1967 , and that death occurred at 12:23 AM from causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE Teodulo Paglinauan, Jr. | | | | 22b. DATE SIGNED August 29, 1967 | | 22c. PHYSICIAN'S NAME (Type) Teodulo Paglinauan, Jr. | |
| 22d. ADDRESS 7620 York Road, Towson, Maryland | | | | 22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or town) (County) (State) | |
| BURIAL | | 9-2-67 | | Mount Auburn Cem. | | Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR MORTON & DYETT F.H. 1701 Laurens Street | | | | 25a. REC'D BY REGISTRAR SEP 1 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10793

CERTIFICATE OF DEATH

10798

| | | | |
|--|--|--|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c. LENGTH OF STAY IN 1b 4 Days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital | | d. STREET ADDRESS 3452 Auchentoroly Terrace | |
| 3 NAME OF DECEASED (Type or print) CLARENCE VENIE | | 4 DATE OF DEATH Month AUGUST Day 19 Year 1967 | |
| 5 SEX Male | 6 COLOR OR RACE Colored | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH June 1, 1894 |
| 9 AGE (In years last birthday) 73 yrs | | 10 IF UNDER 1 YEAR Months Days Hours Min | |
| 11b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | | 11b. KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (County & State or foreign country) Northumberland, Virginia | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Venie | | 14. MOTHER'S MAIDEN NAME Sally Urby | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I | | 16 SOCIAL SECURITY NO 216-12-73-09 | |
| 17 INFORMANT Clin. Rec. VAH, Fort Howard, Maryland | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ADENOCARCINOMA OF PROSTATE WITH METASTASIS DUE TO (b) DUE TO (c) | | | INTERVAL BETWEEN DEATH AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHOPNEUMONIA. GENERALIZED ARTERIOSCLEROSIS | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that he (this hospital) attended the deceased from August 15, 1967 to August 19, 1967 , that he (we) lost saw the deceased alive on August 19, 1967 , and that death occurred at 4:00AM from causes and on the date stated above | | | |
| 22a. SIGNATURE <i>J. D. Talbert</i> | | 22b. DATES SIGNED 8/21/67 | |
| 22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D. | | 22d. ADDRESS VAH FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/24/67 | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland |
| 24. FUNERAL DIRECTOR <i>Earl Gilmore</i> | | 25a. REC'D BY REGISTRAR AUG 24 1967 | |
| 25b. REGISTRAR'S SIGNATURE <i>James J. [illegible]</i> | | | |

1941

1942

1943

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962

1963

1964

1965

1966

1967

1968

1969

1970

1971

1972

1973

1974

1975

1976

1977

1978

1979

1980

1981

1982

1983

1984

1985

1986

1987

1988

1989

1990

1991

1992

1993

1994

1995

1996

1997

1998

1999

2000

2001

2002

2003

2004

2005

2006

2007

2008

2009

2010

2011

2012

2013

2014

2015

2016

2017

2018

2019

2020

2021

2022

2023

2024

2025

2026

2027

2028

2029

2030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10799

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10799

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>28</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Baltimore</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonville, Md. 38</u> | | | | c. LENGTH OF STAY IN 1b <u>5 years</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Caton Ridge Nursing Home - 327 N. 715 W. Saratoga St.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Bessie M. Wales</u> | | | | 4. DATE OF DEATH <u>8</u> <u>14</u> <u>1967</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11/2/1869</u> | |
| 9. AGE (In years last birthday) <u>98</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>William Wolgram</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Wilhelmina ?</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u> | | | | 16. SOCIAL SECURITY NO. <u>2010</u> | | | |
| 17. INFORMANT <u>Mr. Edgar F. Wales</u> | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 441A DUE TO <u>Aspiration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Extreme Senility</u> (c) <u>Years</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ASCVD - Senile Dementia - Multiple Decubiti</u> | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10-16-</u> , 19 <u>62</u> , to <u>8-14-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8-14-</u> , 19 <u>67</u> , and that death occurred at <u>9 1/2</u> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Cesar Valle Caverio</u> | | | | 22b. DATE SIGNED <u>8-14-67</u> | | 22c. PHYSICIAN'S NAME (Type) <u>CESAR VALLE CAVERIO</u> | |
| 22d. ADDRESS <u>8629 Liberty Rd</u> | | | | 22e. REC'D BY REGISTRAR <u>1000 J. T. Johnson</u> | | | |
| 22f. REGISTRAR'S SIGNATURE <u>1000 J. T. Johnson</u> | | | | 22g. DATE <u>AUG 22 1967</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>8/17/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>1000 J. T. Johnson</u> | | | | 25a. REC'D BY REGISTRAR <u>1000 J. T. Johnson</u> | | | |
| 25b. REGISTRAR'S SIGNATURE <u>1000 J. T. Johnson</u> | | | | 25c. DATE <u>AUG 22 1967</u> | | | |

MEDICAL CERTIFICATION



1. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---------------------------|--|---|--|--|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 10800 Item #7 Film #392 9/15/67 pp | | | | | | | | | | | |
| 10800 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Baltimore | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | | | | b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | | | c. LENGTH OF STAY IN 1b 47 days | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dulaney T owson Nursing home | | | | d. STREET ADDRESS Marylander Apts. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last RACHEL LANGMEADE WALLIS | | | | 4. DATE OF DEATH Month Day Year August 31, 1967 | | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> ? DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 16, 1906 | | 9. AGE (In years last birthday) 60 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Sales Manager | | | | 10b. KIND OF BUSINESS OR INDUSTRY Importing Firm | | 11. BIRTHPLACE (County & State, or foreign country) London, England | | 12. CITIZEN OF WHAT COUNTRY? England | | | |
| 13. FATHER'S NAME Isaac Levy | | | | 14. MOTHER'S MAIDEN NAME Esther Greenberg | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 213-30-3510 | | 17. INFORMANT Mrs. Mickey Cox, 305 W. 52nd St. New York, New York 10019 | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>widespread metastatic carcinoma due to adenocarcinoma of breast</u> 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 14 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <i>Edwin H. Stewart, Jr. M.D.</i> | | | | 22b. DATE SIGNED 8/31/67 | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) Edwin H. Stewart, Jr. M.D. | | | | 22d. ADDRESS 721 Medical Arts Bldg Baltimore, Maryland 21201 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION | | | | 23b. DATE THEREOF SEPT. 1, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CREMATORY | | 23d. LOCATION (City, town or county) (State) BALTIMORE, MARYLAND | | | |
| 24. FUNERAL DIRECTOR WM. COOK-BROOKS TOWSON, 1050 YORK ROAD TOWSON, MARYLAND (410) 274-1400 | | | | 25a. REC'D BY REGISTRAR DATE SEP 5 1967 | | | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please restate urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|---|--|
| 10801 | | Item #9 Filed 1/10/67 | | | | | | 10801 | | | |
| Items #10b & 15 Filed 1/10/67 | | | | | | | | | | | |
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Res. dence before admission) a. STATE Maryland b. COUNTY Baltimore | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | | | c. LENGTH OF STAY IN lb Yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1202 Culvert Road | | | | | | d. STREET ADDRESS 1202 Culvert Road | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) HARRY E. WALSTON | | | | | | 4 DATE OF DEATH Month AUGUST Day 6 , Year 19 67 | | | | | |
| 5 SEX Male | | 6 COLOR OR RACE White | | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH | | 9 AGE (In years last birthday) 52 approx. | | IF UNDER 1 YEAR Months 5 Days 2 Hours 5 Min 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager | | | | 10b. KIND OF BUSINESS OR INDUSTRY W.W. Grayer, Inc. | | 11 BIRTHPLACE (County & State, or foreign country) Maryland | | | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Milton J. Walston | | | | | | 14. MOTHER'S MAIDEN NAME Edna Layfield | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16. SOCIAL SECURITY NO. 217-03-0489 | | 17. INFORMANT Address Mrs. Evelyn M. Walston, Same as # 2 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Insufficiency DUE TO Arterial H.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arterial H.D. DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. Month, Day, Year 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21 I certify that (I) (this hospital) attended the deceased from July , 19 67 , to Aug , 19 67 , that (I) (we) last saw the deceased alive on 5/1 , 19 67 , and that death occurred at 7:27 PM , from causes and on the date stated above | | | | | | | | | | | |
| 22a. SIGNATURE C. Edward Leach M.D. | | | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATESIGNED 8/7/67 | | | |
| 22c. PHYSICIAN'S NAME (Type) C. Edward Leach | | | | | | 22d. ADDRESS 14 E. Eager St., Baltimore, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Aug. 10, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery | | 23d. LOCATION (City or Town) (County) (State) Cockeysville, Maryland | | | | | |
| 24 FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204 | | | | | | 25a. REC'D BY REGISTRAR AUG 10 1967 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10802

10802

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kingsville Md</u> c. LENGTH OF STAY IN 1b <u>25 YRS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____ | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u> d. STREET ADDRESS <u>Bradshaw Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Jesse</u> First <u>Wilber</u> Middle <u>Walter</u> Last <u>Meyer</u> 4. DATE OF DEATH <u>Aug. 14</u> Month <u>14</u> Day <u>19</u> Year <u>67</u> | | | | 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 30 1905</u> 9. AGE (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wood Pattern Maker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Empich</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | | | 13. FATHER'S NAME <u>John Woodman Walter Meyer</u> 14. MOTHER'S MAIDEN NAME <u>Margaret Daisy Hines</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>012097917</u> 17. INFORMANT <u>Albert C. Walter Meyer</u> Address <u>Bradshaw Rd.</u> | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>malignant Hypertension</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year _____ Hour _____ a.m. _____ p.m. _____ 19 _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> , to <u>Aug.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug 12 1967</u> , and that death occurred at <u>4:10 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>William A. Tyson</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>WILLIAM A. TYSON.</u> 22d. ADDRESS <u>Kingsville Md.</u> | | | | 22b. DATE SIGNED <u>8-14-67</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>8/17/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u> 23d. LOCATION (City, town or county) <u>TRUMPS MILL RD</u> (State) <u>MD</u> | | | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE _____ 25c. DATE <u>AUG 16 1967</u> | | | |

24. FUNERAL DIRECTOR

ADDRESS

DATE

DIPPEL BROS INC 710 BELAIR RD

AUG 16 1967

Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10803

CERTIFICATE OF DEATH

10803

| | | | |
|--|--|---|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus | | c LENGTH OF STAY IN 1b 03/1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1317 Elm Road | | d. STREET ADDRESS 1317 Elm Road | |
| 3 NAME OF DECEASED (Type or print) EUGENE E. WATTS, JR. | | 4 DATE OF DEATH Month August Day 27 Year 19 67 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-23-1955 |
| 9 AGE (In years last birthday) 12 yrs. | | 10 IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (County & State, or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Eugene E. Watts, Sr. | | 14. MOTHER'S MAIDEN NAME Thelma Herold | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16 SOCIAL SECURITY NO. | |
| 17 INFORMANT Mr. Eugene E. Watts, Sr. | | Address 1317 Elm Road 21227 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C. N. S. Degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hydrocephaly DUE TO (c) | | | |
| INTERVAL BETWEEN ONSET AND DEATH Life | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Willard E. Standiford</i> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Willard E. Standiford | | 22d. ADDRESS 6630 Baltimore National Pike | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF 8-30-1967 | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland |
| 24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | 25a. REC'D BY REGISTRAR DATE AUG 30 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i> | |

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10804

CERTIFICATE OF DEATH

10804

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|----------------------------------|---|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON | | c. LENGTH OF STAY IN 1b 10 W. 50 N | | 2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | | | d. STREET ADDRESS 2537 - A Gatehouse Drive #21207 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Baby | | First Boy | | Middle Weber | | Last 19 67 | |
| 4. DATE OF DEATH August 19 | | Month 19 | | Day 19 | | Year 67 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 28, 1967 | 9. AGE (In years lost birthday) yrs 22 | IF UNDER 1 YEAR Months 22 | | IF UNDER 24 HRS Days 22 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore Co., Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Joseph F. Weber | | | | 14. MOTHER'S MAIDEN NAME Laura J. Kokula | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Sclerema neonatorum DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malnutrition DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 28 , 19 67 , to August 19 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 19 19 67 , and that death occurred at 2:30 AM from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Jose A. Aguto | | M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b. DATE SIGNED August 19, 1967 | | | |
| 22c. PHYSICIAN'S NAME (Type) Jose A. Aguto, M.D. | | 22d. ADDRESS 7620 York Rd, Towson, Md. 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/21/67 | | 23c. NAME OF CEMETERY OR CREMATORY Holy Rosary | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR Joseph N. Zannino 263 S. Conkling Street | | | | 25a. REC'D BY REGISTRAR DATE AUG 29 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

10805

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>BALTIMORE</u> | | c. LENGTH OF STAY in lb <u>BALTIMORE MARYLAND</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u> | | d. STREET ADDRESS <u>7830 OAKLEIGH ROAD</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>HILDA</u> Middle <u>MAE</u> Last <u>WEBER</u> | | 4. DATE OF DEATH Month <u>AUGUST</u> Day <u>26</u> Year <u>1967</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>CAUCASIAN</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-20-09</u> |
| 9. AGE (In years lost birthday) <u>58</u> yrs | | 10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours M.n. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Kent County, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>THOMAS B. NEWCOMB</u> | | 14. MOTHER'S MAIDEN NAME <u>ANNA E. NEWCOMB HADDAWAY</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no UNK</u> | | 16. SOCIAL SECURITY NO <u>212-26-5612</u> | |
| 17. INFORMANT <u>John Raymond Weber--7830 Oakleigh Rd., Balto</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute yellow atrophy, liver</u> DUE TO <u>infectious hepatitis (?)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8/17</u> , 19 <u>67</u> , to <u>8/26</u> , 1967, that (I) (we) last saw the deceased alive on <u>8/26</u> , 19 <u>67</u> , and that death occurred at <u>10:20 A.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>RBreiteneder</u> | | 22b. DATE SIGNED <u>8/26/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>GBMC</u> | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> | 23b. DATE THEREOF <u>8-30-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u> | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u> |
| 24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc....Baltimore, Md....14</u> | | 25a. REC'D BY REGISTRAR <u>AUG 28 1967</u> | |
| 25b. REC'D BY REGISTRAR <u>John R. Ruck</u> | | 25c. REC'D BY REGISTRAR <u>John R. Ruck</u> | |

10806

CERTIFICATE OF DEATH

10806

| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u> | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Randallstown</u> | | c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Baltimore</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hospital</u> | | d. STREET ADDRESS <u>3655 Forest Hill Road #7</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Irving</u> Middle <u>Weksler</u> Last <u></u> | | 4. DATE OF DEATH <u>August 10</u> 19 <u>67</u> Month <u>10</u> Day <u>19</u> Year <u>67</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>25 Dec 1893</u> 73 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Michael Weksler</u> | | 14. MOTHER'S MAIDEN NAME <u>Rose</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO <u>UNKNOWN</u> | |
| 17. INFORMANT <u>Mrs. Mary Weksler, 3655 Forest Hill Road</u> | | 18. ADDRESS <u>#7</u> | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>January</u> , 19 <u>64</u> , to <u>10 Aug</u> , 19 <u>67</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>10 Aug</u> , 19 <u>67</u> and that death occurred at <u>8:00 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Marvin Davis</u> | | 22b. DATE SIGNED <u>11 Aug 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. Marvin Davis</u> | | 22d. ADDRESS <u>6512 Liberty Road</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>8/11/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Chizuk Amuno (Arlington)</u> | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u> | | 25a. REC'D BY REGISTRAR <u>AUG 15 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

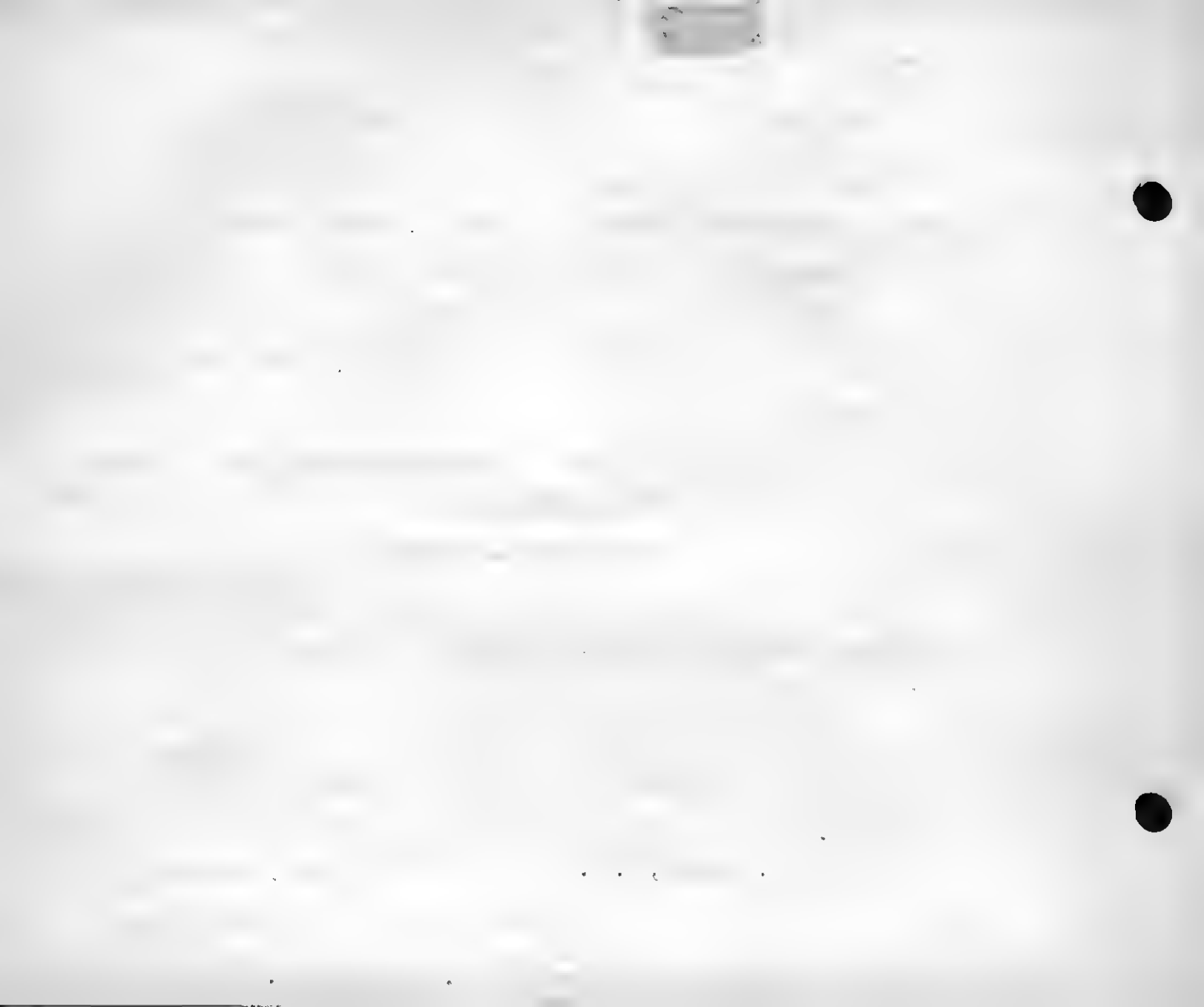
10807

CERTIFICATE OF DEATH

10807

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE MARYLAND b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 21215 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | d. STREET ADDRESS 2727 W. GARRISON AVENUE | |
| 3. NAME OF DECEASED (Type or print) (WILLIAM) WILLIE STOKES WELLS | | 4. DATE OF DEATH Month AUGUST Day 22 Year 1967 | |
| 5. SEX MALE | 6. COLOR OR RACE NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/11/96 |
| 9. AGE (In years last birthday) 71 yrs | | 10. IF UNDER 1 YEAR Months 22 Days 19 Hours 56 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PORTER | | 10b. KIND OF BUSINESS OR INDUSTRY BUILDING | |
| 11. BIRTHPLACE (County & State, or foreign country) ROSEHILL, NORTH CAROLINA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ANDREW WELLS | | 14. MOTHER'S MAIDEN NAME LUCY CARR | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I | | 16. SOCIAL SECURITY NO. 216 01 80 12 | |
| 17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE. EMPHYSEMA, OBSTRUCTIVE | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (this hospital) attended the deceased from 7/23/67 , 19__, to 8/22/67 , 19__, that no (we) last saw the deceased alive on 8/22/67 , 19__, and that death occurred at 3:45AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>John D. Talbert</i> | | 22b. DATE SIGNED 8/23/67 | |
| 22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D. | | 22d. ADDRESS VAH FT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATON, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 8/28/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR <i>Charles R. Law</i> | | 25a. REC'D BY REGISTRAR DATE AUG 24 1967 | |
| 25b. REGISTRAR'S SIGNATURE <i>Charles R. Law</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10808

CERTIFICATE OF DEATH

10808

| | | | | | | | | | |
|--|--|--|-------------------------|--|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1530 Rolling Road | | | | d. STREET ADDRESS 1530 Rolling Road | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) Ralph D. Wheeler, Sr | | | | 4. DATE OF DEATH Month August Day 8 Year 1967 | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6/3/93 | | 9. AGE (In years last birthday) 74 yrs | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY Montgomery Ward | | 11. BIRTHPLACE (County & State or foreign country) Minnesota | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John W. Wheeler | | | | 14. MOTHER'S MAIDEN NAME Lena Atz | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO 215-09-8459 | | 17. INFORMANT Address 21227 Mrs. Annie M. Wheeler, 1530 Rolling Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line, in (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Circulatory Failure DUE TO Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) (c) INTERVAL BETWEEN ONSET AND DEATH 5 hrs | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital), attended the deceased from 2/26 , 19 66 to 8/8 , 19 67 , that (I) (we) last saw the deceased alive on 8/8 , 19 67 , and that death occurred at 8:22 PM , from causes and on the date stated above | | | | | | | | | |
| 22a. SIGNATURE C. Edward Leach | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 8/10/67 | | | |
| 22c. PHYSICIAN'S NAME (Type) Dr. C. Edward Leach | | | | 22d. ADDRESS 14 E. Eager St. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 8/11/67 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | 25a. REC'D BY REGISTRAR DATE AUG 14 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10808

10809

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>BALTIMORE</u> | | c. LENGTH OF STAY IN TB <u>9 DAY</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Agnes Hospital</u> | | d. STREET ADDRESS <u>2716 Fiske St. Ave</u> | |
| 3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First Middle Last | | 4. DATE OF DEATH Month <u>8</u> Day <u>7</u> Year <u>1967</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>NEGRO</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/1/1900</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETAIL CLERK</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>UNKNOWN</u> | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NR-144444444</u> | |
| 17. INFORMANT <u>MR. WILLIAM L. WICKS</u> | | Address <u>2716 Fiske St. Ave</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO <u>Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Heart Failure</u> DUE TO <u>Heart Failure</u> (c) <u>Heart Failure</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC HEART DISEASE</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/27</u> , 19 <u>67</u> , to <u>8/1/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/27</u> , 19 <u>67</u> , and that death occurred at <u>7 A.M.</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>WILLIAM L. WICKS MD</u> | | 22b. DATE SIGNED <u>8/5/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>WILLIAM L. WICKS MD</u> | | 22d. ADDRESS <u>SPRING CROFTS Hospital</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>8-9-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Union Burial Ground</u> | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore City</u> |
| 24. FUNERAL DIRECTOR <u>Morton J. Dyck</u> | | 25a. REC'D BY REGISTRAR <u>FA 1701</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>John J. Jones</u> | | DATE <u>AUG 7 1967</u> | |

CERTIFICATE OF DEATH

10810

10810

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in one event, within 72 hours after death.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY - | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN TB | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, 7620 York Rd. | | d. STREET ADDRESS 920 S. Highland Av. 21224 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) JOHN H. WILLEY | | 4. DATE OF DEATH Month August Day 18 Year 1967 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/19/03 |
| 9. AGE (In years lost birthday) 64 yrs | | IF UNDER 1 YEAR Months 18 Days 18 Hours 18 Min 18 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Crown, Cork & Seal | |
| 11. BIRTHPLACE (County & State, or foreign country) Balto., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Willey | | 14. MOTHER'S MAIDEN NAME Mamie Hartman | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. 213-01-0805 | |
| 17. INFORMANT Nellie M. Willey | | Address Same. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO (b) 0521 DUE TO (c) 0521 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour 0 m 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from August 18, 1967 , to August 18, 1967 , that (I) (we) last saw the deceased alive on August 18, 1967 , and that death occurred at 7:45 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE Lawrence F. Misanik, M. D. | | 22b. DATE SIGNED August 19, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M. D. | | 22d. ADDRESS 7620 York Road Towson 4, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8-22-67 | 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | 23d. LOCATION (City or Town) (County) (State) 7225 Eastern Blvd. Ba. Co., Md. |
| 24. FUNERAL DIRECTOR Charles S. Ziller | | 25a. REC'D BY REGISTRAR AUG 22 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles S. Ziller | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
|---|---------------------------------|--|--|--|---|--|--|
| 10811 | | | | 10811 | | | |
| 1. PLACE OF DEATH a COUNTY BALTIMORE MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c LENGTH OF STAY IN 1b 34 DAYS | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | | | d STREET ADDRESS 2820 BAKER STREET | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last CHARLES M. WILLIAMS | | | | 4 DATE OF DEATH Month Day Year AUGUST 13 19 67 | | | |
| 5 SEX MALE | 6 COLOR OR RACE NEGRO | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JUNE 30, 1927 | | 9 AGE (In years last birthday) yrs 40 | | 10 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PORTER | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (County & State or foreign country) BALTIMORE, MARYLAND | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CHARLES L. WILLIAMS | | | | 14. MOTHER'S M A D E N NAME ELLEN BYRD | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES PL 28 | | 16 SOCIAL SECURITY NO 212 22 13 89 | | 17 INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC RENAL DISEASE, PROBABLE GLOMERULONEPHRITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ADVANCED UREMIC SYNDROME DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH 10 YEARS | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7/11/67 , 19 to 8/13/67 , 19, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/13/67 , 19, and that death occurred at 11:40P from causes and on the date stated above | | | | | | | |
| 22a. SIGNATURE <i>Ahmed Kuty</i> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 8/14/67 | |
| 22c. PHYSICIAN'S NAME (Type) AHMED C. K. KUTTY, M. D. | | | | 22d. ADDRESS VAH FORT HOWARD, MARYLAND | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b DATE THEREOF 8-18-1967 | | 23c NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | | 23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR <i>6014/L 8011</i> | | 25a. REC'D BY REGISTRAR AUG 21 1967 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |
| 24b. FUNERAL HOME WILSON FUNERAL HOME | | 24c. ADDRESS ORLEANS ST. BALTIMORE, MD. | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

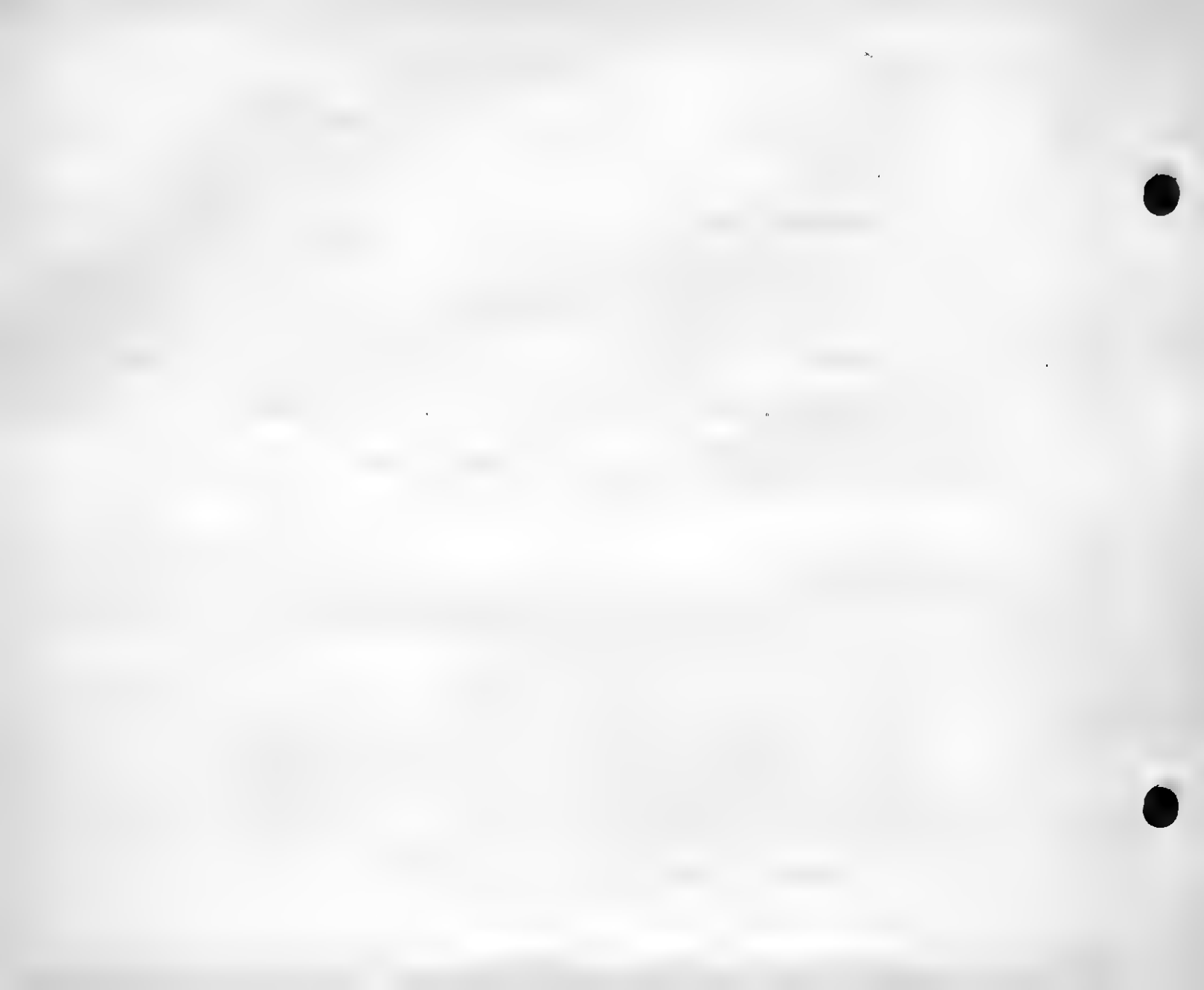
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10812

10812

| | | | | | |
|---|---|--|---------------------------------------|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville | | c. LENGTH OF STAY in 1b 12 yrs | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2511 Burr ridge road | | d. STREET ADDRESS 2511 Burr ridge road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) ROSE B WILLIAMS | | 4 DATE OF DEATH Month Aug Day 20 Year 19 67 | | | |
| 5 SEX F | 6 COLOR OR RACE W | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Dec 19 1913 | 9. AGE (In years last birthday) 53 yrs | IF UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (County & State, or foreign country) New York | |
| 13. FATHER'S NAME Charles F. Maguire | | 14. MOTHER'S MAIDEN NAME Gertrude Laheney | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Family records | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) metastatic carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from August, 1965 to Aug-20, 1967 that (I) (we) last saw the deceased alive on Aug-15 1967 and that death occurred at 8 M, from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Myrton L. Gaines Jr. M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 8/21/67 | |
| 22c. PHYSICIAN'S NAME (Type) Myrton L. Gaines Jr. M.D. | | 22d. ADDRESS 7800 York road | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8/23/67 | 23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem | | 23d. LOCATION (City or Town) (County) (State) Balto Co Md. | |
| 24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford Rd. | | 25a. REC'D BY REGISTRAR AUG 23 1967 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10813

| | | | |
|--|---|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Louis C. Winkelman | | 4. DATE OF DEATH Month Day Year August 22 19 67 | |
| 5 SEX Male | 6. COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH November 1, 1905 |
| 9a USAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-Employed | | 9b. AGE (In years last birthday) 61 yrs | 9c. IF UNDER 1 YEAR Months Days Hours Min |
| 10a USAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-Employed | | 10b. KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland |
| 13. FATHER'S NAME Henry Winkelman | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 14. MOTHER'S MAIDEN NAME Catherine Schlunt | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | |
| 16 SOCIAL SECURITY NO 218-32-1975 | | 17. INFORMANT Mrs. Rose M. Winkelman Address (Same) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinomatosis - primary in pancreas. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 14, 1967 , to August 22, 1967 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on August 22, 1967 , and that death occurred at 1:45 AM from causes and on the date stated above. | | | |
| 22a SIGNATURE Reynaldo Orquela-Gomez, M.D. | | 22b DATE SIGNED August 22, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Reynaldo Orquela-Gomez, M.D. | | 22d. ADDRESS 7620 York Rd., Towson, Md. 21204 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b DATE THEREOF 8/25/67. | 23c NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | 25a. REC'D BY REGISTRAR AUG 23 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE <i>Francis J. Jones</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10814

Item #9 Film #1351 7 ph

CERTIFICATE OF DEATH

10814

| | | | | | | | |
|---|--------------------------------------|--|--|---|--------------------------------------|--|---|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital | | | | d. STREET ADDRESS 4320 Necker Avenue #36 | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3 NAME OF DECEASED (Type or print) First HERMAN Middle Bernard Last WIRSING | | | | 4 DATE OF DEATH Month August Day 6 Year 19 67 | | | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 9-25-95 | 9 AGE (In years last birthday) 71 yrs | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Farmer | | 11 BIRTHPLACE (County & State, or foreign country) Maryland Baltimore | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME Louis Wirsing | | | | 14 MOTHER'S MAIDEN NAME Mary Ann Jasper | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16 SOCIAL SECURITY NO 217-12-8332 | | 17 INFORMANT Address Mrs Anna Wirsing 4320 Necker Avenue | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant lymphoma 2002 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 8-6 , 19 67 , to 8-6 , 19 67 , that (I) (we) lost saw the deceased alive on 8-6 19 67 , and that death occurred at 2:10 p.m. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>Benjamin del Carmen</i> M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 8-6-67 | |
| 22c. PHYSICIAN'S NAME (Type) Benjamin delCarmen, M.D. | | | | 22d. ADDRESS 7620 York Road, Baltimore, Md. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 8-9-1967 | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore Md. | | | |
| 24. FUNERAL DIRECTOR <i>Lassch Funeral Home</i> | | | | 25a. REC'D BY REGISTRAR DATE AUG 8 1967 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10815

CERTIFICATE OF DEATH

10815

| | | | |
|---|-----------------------------------|--|-----------------------------------|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard | | c LENGTH OF STAY IN 1b 6 Hrs 25 Min. | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital | | e STREET ADDRESS 9 S. Stockton Street | |
| 3 NAME OF DECEASED (Type or print) FRED D. WISE | | 4 DATE OF DEATH Month AUGUST Day 28 Year 19 67 | |
| 5 SEX Male | 6 COLOR OR RACE Colored | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 9/15/96 |
| 9 AGE (In years last birthday) yrs 70 | | 10 IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0 | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | | 10b KIND OF BUSINESS OR INDUSTRY B&O Railroad | |
| 11 BIRTHPLACE (County & State, or foreign country) Shenandoah, Virginia | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME Grant Wise | | 14 MOTHER'S MAIDEN NAME Lettie Wilson | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW I | | 16 SOCIAL SECURITY NO 220-07-20-24 | |
| 17 INFORMANT Clin. Rec. VA Hospital, Fort Howard, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA, BILATERALLY, UNDETERMINED ORGANISM INTERVAL BETWEEN DEATH AND DEATH DAYS (b) ENCEPHALOMALACIA, LEFT OCCIPUT; UNKNOWN (c) BASILAR ARTERY ATHEROMATA UNKNOWN (d) CEREBRAL ARTERIOSCLEROSIS UNKNOWN | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE CARDIOVASCULAR DISEASE, ARTERIOLEAR NEPHROSCLEROSIS, ARTERIOSCLEROTIC HEART DISEASE, PULMONARY EMPHYSEMA | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a ACCIDENT WAS UNDERLYING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | |
| 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c TIME OF INJURY Month, Day, Year Hour 19 p.m. | | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/28/ , 19 67 , to 8/28/ , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/28 , 19 67 , and that death occurred at 7:10 PM from causes and on the date stated above. | | | |
| 22a SIGNATURE Neilon Neilson, M.D. | | 22b DATE SIGNED 8/29/67 | |
| 22c PHYSICIAN'S NAME (Type) NEILON NEILSON, M. D. | | 22d ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE THEREOF 9/1/67 | |
| 23c NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery | | 23d LOCATION (City or Town) (County) (State) Baltimore, Maryland | |
| 24 FUNERAL DIRECTOR Hayes Funeral Home | | 25a REC'D BY REGISTRAR 638 N. Gilmor St. Baltimore, Maryland | |
| 25b REGISTRAR'S SIGNATURE Charles Judge | | DATE AUG 31 1967 | |

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

10-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10816

10816

| | | | |
|---|---------------------------------|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institutor on Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson | | c. LENGTH OF STAY IN 'b Baltimore 21205 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, 7620 York Rd. | | d. STREET ADDRESS 534 N. Streeper St. | |
| 3 NAME OF DECEASED (Type or print) First Middle Last WILLIAM H. WOHNER | | 4 DATE OF DEATH Month Day Year August 22 1967 | |
| 5 SEX MALE | 6 COLOR OR RACE WHITE | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April , 1882 85 |
| 9 AGE (In years lost birthday) yrs. 85 | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (County & State, or foreign country) Baltimore, Md. | | 12 CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME August A. Wohner | | 14 MOTHER'S MAIDEN NAME Mary Manlin | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16 SOCIAL SECURITY NO 218-69-4127A | |
| 17 INFORMANT Mr. George Wohner | | Address 534 N. Streeper St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Thrombosis of basilar artery DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Infarction of pons | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that (a) (this hospital) attended the deceased from August 18, 1967 to August 22, 1967 , that (b) (we) last saw the deceased alive on August 22, 1967 , and that death occurred at 7:55 PM , from causes and on the date stated above | | | |
| 22a. SIGNATURE Reynaldo Orjuela-Gomez, M.D. | | 22b. DATE SIGNED August 23, 1967 | |
| 22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D. | | 22d. ADDRESS 7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Aug 24/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY St. Charles Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore | |
| 24. FUNERAL DIRECTOR Philip Herwig Sons | | 25a REC'D BY REGISTRAR 2024 Orleans St | |
| 25b REGISTRAR'S SIGNATURE Charles Judge | | DATE AUG 25 1967 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician, and in by the funeral director. After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 10817 Item #2c & d Film 10817 7/1/67 ph | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 10817 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE MD c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUMMIT CONV. HOME | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE MD 21222 d. STREET ADDRESS 99 Smithwood Ave e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| 3. NAME OF DECEASED (Type or print) First LEE Middle W. Last WOLF | | | 4. DATE OF DEATH Month August Day 26 Year 1967 | | | 5. SEX M | | | 6. COLOR OR RACE W. | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH Oct 22, 1883 | | | 9. AGE (In years last birthday) 83 yrs. | | | 10. IF UNDER 1 YEAR Months 26 Days 26 Hours 1967 | | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | 12. KIND OF BUSINESS OR INDUSTRY Builder | | | 13. BIRTHPLACE (County & State, or foreign country) BALTO. MD | | | 14. CITIZEN OF WHAT COUNTRY? U.S.A | | |
| 15. FATHER'S NAME Wm. Wolf | | | 16. MOTHER'S MAIDEN NAME Laura Wolf | | | 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | 18. SOCIAL SECURITY NO. 213-05-1458 | | |
| 19. INFORMATION Address From Summit Nursing Home record | | | 20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. DUE TO Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUETO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (c) Coronary Artery Disease & C.H.F. | | | 21. INTERVAL BETWEEN ONSET AND DEATH Weeks Years | | | 22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 23. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | 25. TIME OF INJURY Hour a.m. 19 p.m. | | | 26. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | |
| 27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 28. (City or town) | | | 29. (County) | | | 30. (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 4/18/1967 to 8/26/1967 , that (I) (we) last saw the deceased alive on 8/26/1967 , and that death occurred at 5:20 A M, from the causes and on the date stated above. | | | | | | | | | | | |
| 22. SIGNATURE Adnan Sonmez M.D. | | | | | | 23. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 24. DATE SIGNED 8/26/1967 | | |
| 25. PHYSICIAN'S NAME (Type) ADNAN SONMEZ | | | | | | 26. ADDRESS 1011 Frederick Road | | | | | |
| 27. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 28. DATE THEREOF 8/28/67 | | | 29. NAME OF CEMETERY OR CREMATORY McADAMRIDGE CEM. | | | 30. LOCATION (City, town or county) (State) Howard Co. Md. | | |
| 31. FUNERAL DIRECTOR'S SIGNATURE E & Mac Nabbe | | | | | | 32. ADDRESS 301 Frederick Rd Balto 28 Md | | | 33. REC'D BY REGISTRAR AUG 28 1967 | | |
| 34. REGISTRAR'S SIGNATURE Charles Judge | | | | | | 35. DATE AUG 28 1967 | | | | | |

1
FOR STATE
HEALTH DEPT.
2
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
|--|--|--|-------------------------|---|--|---|--|---|--|--|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 10818 | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>White Marsh Baltimore life</u> | | | c. LENGTH OF STAY IN lb | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>White Marsh - Balto - rural</u> | | | d. STREET ADDRESS <u>Bx 486 Philadelphia Del</u> | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>gun powder river near Rt 7</u> | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Janet Edna Wollschlager</u> | | | | | 4. DATE OF DEATH Month Day Year <u>Aug 29 1967</u> | | | | | | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>8 Feb 1960</u> | | 9. AGE (In years last birthday) <u>7</u> yrs. | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <u>Student</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Donald Walter Wollschlager</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Harriet V. Bethouille</u> | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address Road <u>Mr Donald W. Wollschlager Box 486 Philadelphia</u> | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>DROWNING</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>alone.</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>undet.</u> | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell into tributary of Gunpowder at flood</u> | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>4:12</u> p.m. <u>8-27</u> 19 <u>67</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>River waters</u> | | 20f. (City or town) (County) (State) <u>White Marsh Balto Co Del</u> | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>John C. Hyle</u> | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | |
| EXAMINER'S NAME (Type) <u>JOHN C. HYLE</u> | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | |
| | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>7527 Barclay Rd Balto 36</u> | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9-1-1967</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u> | | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore, Co. Md.</u> | | | | | | | |
| 23. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Rd</u> | | | | | 24a. REC'D BY REGISTRAR <u>36</u> | | | | | 24b. REGISTRAR'S SIGNATURE <u>Charles Jones</u> | | | | |
| DATE <u>SEP 5 1967</u> | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 10819 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____ | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Towson | | | | c. LENGTH OF STAY IN ID 13 days | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 30-4 | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Greater Baltimore Medical Center | | | | | | d. STREET ADDRESS 108 West 39th St. 10 | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Francis Wheeler Wrightson | | | 4. DATE OF DEATH Month 8 Day 4 Year 1967 | | | 5. SEX Male | | | 6. COLOR OR RACE Cau | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | 8. DATE OF BIRTH Sept. 26, 1897 | | | 9. AGE (In years last birthday) 69 yrs. | | | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chairman of Board | | | | 10b. KIND OF BUSINESS OR INDUSTRY Provident Savs. Bk. | | 11. BIRTHPLACE (County & State, or foreign country) West Virginia | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME Rev. James O. Wrightson | | | | | | 14. MOTHER'S MAIDEN NAME Annie Fisher | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | 16. SOCIAL SECURITY NO. World War I | | 17. INFORMANT Address Mrs. Charlotte B. Wrightson same address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pyelonephritis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic hypertensive cardiovascular disease | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | 21. I certify that (I) (this hospital) attended the deceased from 7/23 , 19 67 , to 8/4 , 19 67 , that (I) (we) last saw the deceased alive on 8/4 , 19 67 , and that death occurred at 12:45 from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE John E. Adams | | | | 22b. DATE SIGNED p.m. 8/5/67 | | | | 22c. PHYSICIAN'S NAME (Type) John E. Adams, M.D. | | | |
| 22d. ADDRESS 6701 N. Charles Street | | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | |
| 23b. DATE THEREOF 8/7/67 | | | | 23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery | | | | 23d. LOCATION (City, town or county) (State) Woodlawn, Md. | | | |
| 24. FUNERAL DIRECTOR Wm. F. Fickner & Sons | | | | 25a. REC'D BY REGISTRAR Wm. F. Fickner | | | | 25b. REGISTRAR'S SIGNATURE John Charles Judge | | | |
| DATE AUG 8 1967 | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10820

CERTIFICATE OF DEATH

10820

| | | | |
|--|---|--|--|
| 1 PLACE OF DEATH a COUNTY BALTIMORE MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL | | d STREET ADDRESS 1727 E. Lombard Street | |
| 3 NAME OF DECEASED (Type or print) First BILL Middle Last YABLECKI | | 4 DATE OF DEATH Month AUGUST Day 11 Year 19 67 | |
| 5 SEX MALE | 6 COLOR OR RACE WHITE | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8 DATE OF BIRTH 5/15/93 |
| 9 AGE (In years lost birthday) 74 yrs | | 10 IF UNDER 1 YEAR Months Days Hours Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TIN PLATE WORKER | | 10b KIND OF BUSINESS OR INDUSTRY BETH STEEL CO. | |
| 11 BIRTHPLACE (County & State or foreign country) POLAND | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME FELIX YABLECKI | | 14 MOTHER'S MAIDEN NAME NAME UNKNOWN | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I | | 16 SOCIAL SECURITY NO 213 09 07 96 | |
| 17 INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ADENOCARCINOMA WITH ABDOMINAL METASTASES DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH MONTHS |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE WITH CHRONIC ATRIAL FIBRILLATION. | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m. | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) | 20f (City or town) (County) (State) |
| 21. I certify that (X) (this hospital) attended the deceased from 5/29/67 , 19 to 8/11/67 , 19, that (X) (we) last saw the deceased alive on 8/11/67 , 19, and that death occurred at 6:10A M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>John D. Talbert</i> | | 22b. DATE SIGNED 8/11/67 | |
| 22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D. | | 22d. ADDRESS VAH FT HOWARD, MARYLAND | |
| 23a BURIAL CREMATION, REMOVAL (Specify) BURIAL | 23b DATE THEREOF AUG 14 1967 | 23c NAME OF CEMETERY OR CREMATORY HOLY CROSS CEMETERY | 23d LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND |
| 24 FUNERAL DIRECTOR | | 25a REC'D BY REGISTRAR DIPPEL BROTHERS FUNERAL HOME DATE AUG 15 1967 25b REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

DIPPEL BROTHERS FUNERAL HOME
LOMBARD & ANN STREETS, BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

10821

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10821

| | | | |
|---|---|--|--|
| 1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 3 YRS 12 DA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Forest Haven Nursing Home Ingleside Ave | | e. STREET ADDRESS 1809 Lancaster Street | |
| 3 NAME OF DECEASED (Type or print) First Martin Middle Yanka Last Yanka | | 4. DATE OF DEATH Month August Day 27 Year 1967 | |
| 5 SEX Male | 6 COLOR OR RACE Caucasian | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH APRIL 15 1881 |
| 9 AGE (In years last birthday) 86 yes | | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor | | 10b KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (County & State, or foreign country) Poland | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Henry Yanka | | 14 MOTHER'S MAIDEN NAME Elizabeth | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16 SOCIAL SECURITY NO 218-10-2186 | |
| 17 INFORMANT Eva Grochowina | | Address 1809 Lancaster St Balto. Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 4221 IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC CORONARY CALCULUS DUE TO MISSING EMBOLIC ENDOTHRAL (ARTS) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (u) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21. I certify that (I) (the hospital) attended the deceased from 8/15 , 19 67 , to 8/27 , 19 67 that (I) (we) last saw the deceased alive on 8/27 , 19 67 , and that death occurred at 7:27 p.m. from causes and on the date stated above. | | | |
| 22a SIGNATURE Dr. John H. Shaw | | 22b. DATE SIGNED 8/28/67 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. John H. Shaw M.D. | | 22d ADDRESS 5800 Edmondson Ave. Balto. Md. | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b DATE THEREOF AUG 30 1967 | 23c NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY | 23d LOCATION (City or Town) (County) (State) GERMAN HILL RD BALTO MD |
| 24. FUNERAL DIRECTOR Dippel Bro's Inc. 1800 E. Lombard St. Balto Md. | | 25a. REC'D BY REGISTRAR AUG 30 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

10822

CERTIFICATE OF DEATH

10822

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD b. COUNTY CARROLL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GARRISON | | c. LENGTH OF STAY IN 1b 24 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FORLEIGH NURSING HOME | | e. STREET ADDRESS 176 W MAIN ST | |
| 3. NAME OF DECEASED (Type or print) ETTA BLANCHE YOUNG | | 4. DATE OF DEATH 8 29 19 67 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JAN 26 1882 |
| 9. AGE (In years, last birthday) 85 yrs | | 10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State or foreign country) CARROLL CO. MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME LEANDER GLADHILL | | 14. MOTHER'S MAIDEN NAME BELLE FORREST | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. ? | |
| 17. INFORMANT CHARLES R. YOUNG WESTMINSTER MD | | Address 176 W. Main St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus | | INTERVAL BETWEEN ONSET AND DEATH 10 min | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 8-5 , 19 67 , to 8-29 , 19 67 , that (I) (we) last saw the deceased alive on 8-28 , 19 67 , and that death occurred at 3:55 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE David J. Miller MD | | 22b. DATE SIGNED 8/29/67 | |
| 22c. PHYSICIAN'S NAME (Type) David J. Miller | | 22d. ADDRESS Lisuan Rd. Cwing-Mk, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF 9/1/67 | 23c. NAME OF CEMETERY OR CREMATORY Kriders Cemetery | 23d. LOCATION (City or Town) (County) (State) Rural, Westminister, Md |
| 24. FUNERAL DIRECTOR J. S. 272 York Jr., Westminister, Md. | | 25a. BY REG. STRA SEP 1 1967 25b. REG. STRA'S SIGNATURE J. S. 272 York Jr. | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10824

10824

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY _____ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville | | c. LENGTH OF STAY IN 1b 7yrlmth14dys | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Ruth Middle Youse Last Youse | | 4. DATE OF DEATH Month August Day 15 Year 1967 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 15, 1894 |
| 9. AGE (In years last birthday) 73 yrs. | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist | | 10b. KIND OF BUSINESS OR INDUSTRY Art | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME Christian Youse | | 14. MOTHER'S MAIDEN NAME Louise Ebert | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. 219-54-3482T | |
| 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) 4391 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) | |
| 20c. TIME OF INJURY Hour a.m. Month, Day, Year 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that 7 (this hospital) attended the deceased from July 1, 1960 to Aug. 15, 1967 , that 7 (we) last saw the deceased alive on Aug. 15, 1967 , and that death occurred at 4:05 P. M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Anthony J. Young, M.D.</i> | | 22b. DATE SIGNED 8-16-67 | |
| 22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D. | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Aug. 18, 1967 | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland |
| 24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson | | 25a. REC'D BY REGISTRAR AUG 18 1967 | |
| ADDRESS 1050 York Road Towson, Maryland 21204 | | 25b. REGISTRAR'S SIGNATURE <i>Frank J. [Signature]</i> | |

SECRET

CONFIDENTIAL

SECRET

SECRET

CONFIDENTIAL

SECRET

CONFIDENTIAL

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

CONFIDENTIAL

CONFIDENTIAL

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

SECRET

10825

CERTIFICATE OF DEATH

10825

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>333 Harlem Lane,</u> c. LENGTH OF STAY IN 1b <u>3 weeks</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shangri-La Nursing Home</u> | | d. STREET ADDRESS <u>3213 Howard Park Avenue</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Charles William Zimmerman</u> | | 4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1967</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Caucasian</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-10-1874</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk U.S. District Court</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) <u>93</u> yrs. |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Bernhardt T.W. Zimmerman</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>Robert Zimmermann</u> | | Address <u>3213 Howard Pk. Ave</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u></u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>10 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Parkinson's Disease</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (1) <u>this hospital</u> attended the deceased from <u>October</u> , 19 <u>64</u> , to <u>August</u> , 19 <u>67</u> , that (1) <u>was</u> last saw the deceased alive on <u>August 23</u> , 19 <u>67</u> , and that death occurred at <u>9:30</u> A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Millard T. Traband, Jr.</u> | | 22b. DATE SIGNED <u>25 Aug. 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Millard T. Traband, Jr.</u> | | 22d. ADDRESS <u>1811 North Rolling Road, Baltimore, Md. 21207</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>8-28-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Ellsworth Armacost</u> | | 25a. REC'D BY REGISTRAR <u>AUG 28 1967</u> | |
| ADDRESS <u>-4600 Liberty Hgts. Ave.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

